REPORT OF THE COMMITTEE
OF INQUIRY ON

The Rehabilitation Training and Resettlement of Disabled Persons

Presented by the Minister of Labour and National Service to Parliament
by Command of Her Majesty
November 1956

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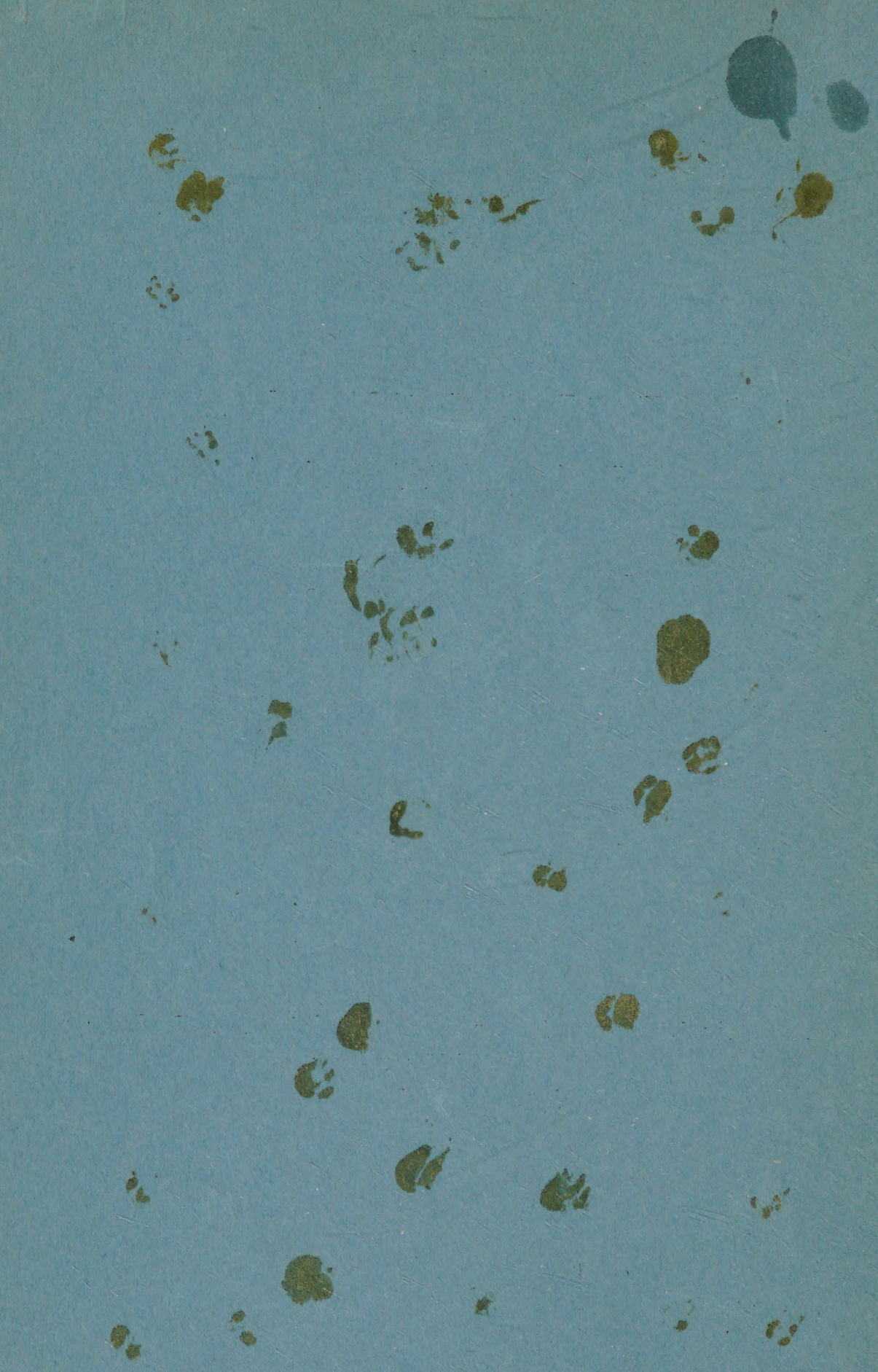

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MEMBERSHIP OF THE COMMITTEE

Chairman: The Rt. Hon. LORD PIERCY, C.B.E.

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Sir CLAUDE FRANKAU, C.B.E., D.S.O., M.S., F.R.C.S.	Ministry of Health;
ANTHONY GREENWOOD, Esq., M.P.	
DAME FLORENCE HANCOCK, D.B.E.	National Woman Officer of the Transport and General Workers' Union;
Miss J. HOPE-WALLACE‡	National Assistance Board;
J. H. F. LUDGATE†, Esq., C.B.E. ...	Ministry of Pensions and National Insurance.
Dr. C. GAULTER MAGEE, C.B.E., F.R.C.P., Q.H.P.	Ministry of Pensions and National Insurance;
J. E. PATER, Esq., C.B.	Ministry of Health;
A. B. TAYLOR, Esq.	Department of Health for Scotland;
P. H. ST. JOHN WILSON, Esq., C.B., C.B.E.	Ministry of Labour and National Service;
The Hon. RICHARD WOOD§, M.P.	

Joint Secretaries:

Mr. G. C. H. SLATER, C.B.E. ...	Ministry of Labour and National Service;
Mr. T. C. L. NICOLE, T.D.	Ministry of Health.

* Succeeded G. R. K. Lee, Esq., on 18th December, 1953.
† Succeeded Dame Marjorie Cox, D.B.E., Ministry of Pensions on 3rd October, 1953.
‡ Succeeded I. McG. Roberton, Esq., Ministry of National Insurance on 3rd October, 1953.
§ Resigned on 11th January, 1956, on appointment as a Parliamentary Secretary to Ministry of Pensions and National Insurance.

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REPORT OF THE COMMITTEE OF INQUIRY ON THE REHABILITATION OF DISABLED PERSONS

To the Right Honourable IAIN MACLEOD, M.P., Minister of Labour and National Service, the Right Honourable R. H. TURTON, M.C., M.P., Minister of Health, and the Right Honourable JAMES STUART, M.V.O., M.C., M.P., Secretary of State for Scotland.

INTRODUCTORY

(a) Appointment of the Committee

1. The Committee was appointed in March, 1953, jointly by the Minister of Labour and National Service, the Minister of Health and the Secretary of State for Scotland, with the following terms of reference:—

> "To review in all its aspects the existing provision for the rehabilitation, training and resettlement of disabled persons, full regard being had to the need for the utmost economy in the Government's contribution, and to make recommendations."

2. The decision to set up the Committee arose out of a recommendation made to the Minister of Labour and National Service in October, 1952, by the National Advisory Council on the Employment of the Disabled. The Council suggested that it was time to consider the developments that had taken place, in the light of the knowledge gained since the Interdepartmental Committee on the Rehabilitation and Resettlement of Disabled Persons (the Tomlinson Committee) issued its report in 1943.

3. The setting up of the Committee was announced by the Minister of Labour and National Service in a statement made in the House of Commons on 12th March, 1953. In reply to questions, the Minister stated that it was not intended to limit the terms of reference in any way and that the review was to cover disabled persons of all kinds.

4. The first meeting of the Committee was held on 28th April, 1953, and altogether 54 meetings were held. In addition to regular meetings, the Committee visited hospitals, industrial rehabilitation units, Remploy factories, sheltered workshops, employment exchanges and other establishments. It also visited Scotland to study the Scottish aspects of the problems under review, to hear oral evidence from certain Scottish bodies, and to visit a number of Scottish institutions providing services for the disabled.

(b) Interpretation of Terms of Reference

5. The term "rehabilitation" in its widest sense signifies the whole of the process of restoring a disabled person to a condition in which he is able as early as possible to resume a normal life. With this interpretation, it would cover also training and resettlement in employment. As the terms of reference specifically mention rehabilitation, training and resettlement, the Committee decided that its use of the term "rehabilitation" should be confined to medical and surgical treatment designed to restore physical and mental functions and to the process of re-conditioning designed to restore the capacity for taking up employment or vocational training. Whilst the Committee was concerned primarily with vocational training of the disabled, it decided that it would take account also of other forms of training of the disabled, more strictly educational in content. It also decided that the term "resettlement" should be used to cover both the placing of disabled persons in employment (including any follow-up action to ascertain the effectiveness of the placing) and action taken to resettle other disabled persons—such as housewives—who are not in the industrial field.

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6. The Committee decided that for its purpose a disabled person should be regarded as one suffering from some physical or mental impairment. Within this wide definition the Committee has not restricted its consideration by age or by category or cause of disablement. It has, however, excluded the aged whose only disability is age itself and it has assumed that a disabled person is to be regarded as one whose disability involves a real handicap of more than temporary significance in living or working.

(c) **Consideration of Evidence**

7. Written evidence was invited from outside bodies and individuals, and the very considerable response from voluntary organisations and others demonstrated the interest in the subject under review and the thought given to it. Many of the organisations and some of the individuals submitting written evidence were invited to give oral evidence to the Committee in support of their written memoranda. The Committee found this evidence most useful and wishes to record its appreciation of the assistance rendered by the various organisations and individuals. (A list of those giving evidence will be found in Appendix A.) In addition the Committee considered the large number of resolutions submitted to the Minister of Labour by Disablement Advisory Committees and received oral evidence from representatives of six of these Committees. The Committee also received oral evidence from the National Advisory Council on the Employment of the Disabled, the Advisory Council for the Welfare of Handicapped Persons and the Scottish Advisory Council for the Welfare of Handicapped Persons.

(d) **Brief Historical Sketch**

8. While the full history of the rehabilitation services in this country is of great interest, it is sufficient for the purposes of this Report to record some of the salient features of their development.

9. Like most organised medical and social services, the rehabilitation services had their origin in voluntary effort. On the one hand there were voluntary hospitals which took an interest in their patients beyond the stage when in-patient treatment for acute illness had been completed and did pioneer work in the development of hospital rehabilitation services. On the other hand, local and national organisations grew up with the general object of fostering the welfare of, and sometimes finding employment for, various types of permanently disabled people—the war disabled, the blind, the deaf and the crippled.

10. When the State entered this field it did not seek to replace voluntary effort but rather to provide improved services and to extend these services throughout the whole country. Indeed, the volume and variety of voluntary effort for the disabled is probably greater now than it has ever been. The entry of the State appears to have acted both as a stimulus and as a challenge to voluntary effort. The financial assistance that voluntary organisations may obtain when working as agents for government departments or local authorities has been a source of encouragement, but the major factor is clearly that the public conscience has become increasingly alive to the needs of the disabled. In recent years valuable help has been organised for groups that had previously been somewhat neglected, e.g., spastics and epileptics. There are now few types of disablement, major or minor, for which there is not at least one interested voluntary organisation.

11. The development of rehabilitation was greatly influenced by the two World Wars. One of the early influential events was the establishment by Sir Robert Jones of a series of rehabilitation departments in the military orthopaedic hospitals during the First World War; these were designed to

halt the serious loss of manpower caused by insufficient after-care of severe fractures and other orthopaedic disabilities sustained on active service. Between the wars, however, this lesson was largely forgotten, and had to be learnt again with the stimulus provided by the British Medical Association's Committee on Fractures in 1935, and by the Delevingne Committee on the Rehabilitation of Persons Injured in Accidents in 1939. The introduction of the Emergency Hospital Scheme during the Second World War made it possible both to organise special centres on a national basis and through the outstanding contribution of Sir Robert Stanton Woods to promote hospital rehabilitation services. The value of organised rehabilitation was further demonstrated by the experience of the Services in the centres provided for Service casualties. During the Second World War Mr. Ernest Bevin as Minister of Labour introduced in 1941 a scheme for the training and resettlement of disabled persons in order to bring into wartime employment every possible man and woman. The expansion of this scheme prompted the setting up of the Tomlinson Committee on whose recommendations the present provisions for the resettlement of the disabled are largely based. The following provide the basis of the existing services:—

Disabled Persons (Employment) Act, 1944—making further and better provision for enabling persons handicapped by disablement to secure employment.

Education Act, 1944 and Scottish Education Act, 1946—providing amongst other things, special educational facilities and training for disabled children.

National Insurance Act, 1946—providing insurance benefits for disabled persons unfit to work or unable to find it.

National Insurance (Industrial Injuries) Act, 1946—superseding the Workmen's Compensation Acts and providing benefit and pensions for those injured or contracting prescribed disease at work.

National Health Service Act, 1946, and National Health Service (Scotland) Act, 1947—providing for medical and hospital treatment and after-care and the supply of surgical and other appliances.

National Assistance Act, 1948—making provision, amongst other things, for the welfare of persons substantially and permanently handicapped by illness, injury or congenital deformity.

Royal Warrants and corresponding Orders—providing for pensions and allowances for ex-members of the Forces suffering from disablement due to service—Statutory Schemes—providing similar benefits for members of the Mercantile Marine etc. and civilians who are disabled as a result of war injuries or war service injuries.

12. Two points about the above legislation are noteworthy. The first is that it has not usually been the practice to make legislative provision exclusively for the disabled. The medical or social services are ordinarily provided for the general population but they include legislative or administrative provisions to meet the special needs of the disabled. For example, medical treatment under the National Health Service Acts is inclusive of treatment which takes the form of rehabilitation. Similarly, the powers of local authorities under the National Assistance Act include powers to provide services to the "substantially and permanently handicapped". Even the Disabled Persons (Employment) Act, 1944, did not provide an entirely new set of services; in certain respects it enabled the Ministry of Labour to adapt its existing services so as to meet more effectively the needs of the disabled for training and placement. The National Insurance (Industrial Injuries) Act is an exception to this general practice.

13. The second point is that although State intervention by way of legislation has been piecemeal, yet stage by stage legislation has covered the whole ground. The Committee's views on how these various Acts have worked in practice are given in the Report.

(e) **Method used in setting out the report**

14. The report is produced under subject headings. It begins with a consideration of the available statistics bearing upon the size of the problem; thereafter so far as possible the remainder of the report is laid out in chronological sequence. Starting with the medical contribution it follows on with chapters on industrial rehabilitation, welfare services and vocational training. The employment contribution is dealt with in two chapters, the first covering ordinary employment and the second sheltered employment. Then follows a chapter on home working schemes and another on categories of disabled where special conditions apply. There are chapters on administrative arrangements, voluntary effort and financial considerations and the report concludes with a short summing up and a comprehensive note of the main conclusions of the Committee and its recommendations.

15. Each chapter contains a summary of the main facts about the existing facilities in so far as these are relevant to the terms of reference of the Committee. A more detailed account of these facilities has recently been published for the Standing Resettlement and Rehabilitation Committee under the title "Services for the Disabled" (S.O. Code No. 36–217).

CHAPTER I. THE SIZE OF THE PROBLEM

16. Desirable as it may have been for the Committee to have gained some idea of the numbers of disabled persons throughout the country, no comprehensive figures are available; and indeed it is hardly reasonable to expect to find any in a form suitable for the purposes of the Committee's inquiry. There are figures indicating the numbers of special categories of disabled persons suffering from particular disabilities, but the number of people for whom some sort of rehabilitation is needed cannot be estimated with any certainty. The Committee doubts whether with the most elaborate machinery, comprehensive statistics could be compiled and it considers that, in any case, the cost would not be justified.

17. In the limited fields covered by the Disabled Persons (Employment) Act fairly comprehensive statistics are compiled of those registering voluntarily under that Act because injury, disease or congenital disability substantially handicaps them in obtaining or keeping employment. These statistics, although not complete because registrations are made voluntarily and frequently are not renewed, give a reasonably good indication of the number of disabled persons in need of help in obtaining or retaining employment. Appendix B shows the composition by types of disability of persons registered under the Disabled Persons (Employment) Act and shows that the total at 16th April, 1956, was 798,279.

18. No reliable figures are available of disabled persons outside the employment field. All local authorities keep registers of blind persons and the majority of local authorities are now also compiling registers of others who wish to use welfare facilities provided under the National Assistance Act. By this means local authorities are able to assess the welfare needs of the disabled within their locality, but it is not possible from these registers to arrive at a fully comprehensive figure covering the total number of disabled persons throughout the country, if only because

the range of welfare facilities available in any area will affect the number of those who register.

19. The British Medical Association gave the Committee an estimate of at least 50,000 individuals per year probably requiring some form of special rehabilitation which they referred to as "planned convalescence". This estimate, said to be deliberately placed on the low side and not based on precise data, was intended to act more as a pointer to the need for additional facilities than as an exact statement.

20. Both the British Medical Association and the Ministry of Health drew the Committee's attention to the result of a survey made at King's College Hospital in 1950 of the occupational prognosis of 1,000 consecutive and unselected patients discharged from wards during a period of two months, covering all categories of patients including children. It was estimated that 74·2 per cent. of the patients would recover fully on discharge, 10·2 per cent. would, although left with some permanent disability, be able to resume their work or normal place in the community, 15·1 per cent. would be permanently unsuitable for continuous full-time work and 0·5 per cent. would need to be trained for new work. The British Medical Association also drew attention to figures produced by the R.A.F. which indicated that at least 25 per cent. of orthopaedic cases required special facilities for rehabilitation. As mentioned later (Chapter II, para. 40), an investigation into the hospital treatment of an unselected group of male patients suffering from acute medical conditions at four hospitals in the west of Scotland revealed that of 548 patients who were seen three months after leaving hospital 55·5 per cent. had returned to work, 10·8 per cent. were outside the ordinary age of work and 33·7 per cent. were of working age but had not returned to work.

21. The Committee also examined a number of statistics extracted from the Ministry of Pensions and National Insurance "Digest of Statistics Analysing Certificates of Incapacity, 1953–54". The more relevant statistics are given in Appendix C. The information available, from which these statistics were prepared, relates only to the doctor's diagnosis of the cause of incapacity and personal details such as age and sex and the duration of the illness. There is no information about the suitability of the individuals for rehabilitation. Tables provided by the Ministry of Pensions and National Insurance could, therefore, only indicate the numbers of persons who suffered long illnesses and their age distribution.

22. In order to assist the Committee the Ministry of Pensions and National Insurance provided summary tables giving this information about claimants certified as incapable of work owing to sickness on 5th June, 1954. These tables made possible the identification of those groups who would appear to be most likely to benefit if more active steps were taken to help them to move at an earlier stage out of the category of sick persons into work or occupation. Omitting the elderly, short-term sick and long-term chronic sick, the tables showed that 85,000 men and women between 15 and 54 years of age had been incapacitated for work for periods ranging from six months to two years. A proportion of these people would be suffering from unstable or permanent disabilities and might, therefore, be unlikely to benefit from rehabilitation facilities, and an unknown number, but almost certainly less than 20 per cent., would be in hospital. Whatever allowances are made, however, the figures suggest that the number of those who might benefit from rehabilitation facilities is probably considerable, though with so many questions unanswered not even a rough estimate of the actual number is possible.

23. The Committee RECOMMENDS, therefore, that enquiry should be made to find out how many persons receiving sickness benefit for more than six months could be assisted in a return to work if suitable facilities for rehabilitation or resettlement were made available for them. The enquiry might also suggest the extent to which particular facilities were required.

24. The Committee obtained another pointer towards the size of the problem when they considered the work undertaken by the regional medical officer service of the Health Departments.

25. In 1955, 586,700 claimants for sickness benefit and 68,400 claimants for injury benefit were referred for medical report by the Ministry of Pensions and National Insurance to the regional medical officer service. Forty-six per cent. were considered to be incapable of work and 2 per cent. incapable of their former work but fit for alternative work (usually of a restricted kind). These figures include a large number of claimants with short-term illnesses who, in the main, are not in the rehabilitation field, but most long-term claimants for whom there is any prospect of resumption of work are referred for report within twelve months of becoming incapable, and it would be reasonable to assume that a fair number of these long-term claimants might benefit from better rehabilitation facilities. At present very few are recommended for rehabilitation courses by the regional medical service. The Committee considers this question in Chapter II, para. 64.

26. Notwithstanding the advances of the last ten years there does therefore seem room for substantially greater use to be made of existing provisions for speeding-up the return to work of those temporarily or permanently handicapped by injury or disease and for some increased provision to be made for this purpose. The Committee has taken it as axiomatic that in a modern community provision for the earliest possible return of the disabled to the normal life of work and leisure has a high priority in the tasks which the State assumes, for economic as well as humanitarian reasons. It has seemed to the Committee, however, that considerable progress towards a comprehensive scheme of rehabilitation is possible at comparatively small expense if existing techniques and facilities are used to the full at the earliest practicable moment by all those concerned with the care of the disabled, including the disabled person himself. To a large extent the necessary pioneering and experimental work has been done and has proved its worth. The first problem to be tackled may then well be the spreading of knowledge and understanding, the increase of co-operation and the breaking-down of compartments. From the volume and quality of the evidence submitted to it, the Committee is in no doubt that the leaders in the various fields are working to this end, and accordingly hopes that this report will speed its fulfilment.

CHAPTER II. THE MEDICAL CONTRIBUTION TO THE REHABILITATION OF THE DISABLED

27. To the layman the medical aspects of disablement will come most readily to mind, to the exclusion perhaps of other important factors. To the medical practitioner, " disablement " is not a single or simple physical condition, but embraces a wide variety of conditions which may require medical or surgical treatment and rehabilitation services of different forms and from different agencies. The British Association of Physical Medicine, in

giving evidence, distinguished four main groups of physically disabled persons each with its own particular rehabilitation problems:—

(*a*) Those patients for whom full recovery is to be expected.

(*b*) Those with permanent but stable disabilities such as amputation, blindness or paralysis resulting from poliomyelitis.

(*c*) Those with unstable disabilities such as tuberculosis, rheumatoid arthritis and peptic ulcers.

(*d*) Those with chronic and degenerative disorders such as osteoarthritis and disseminated sclerosis.

Those with unstable disabilities will obviously be more difficult to train or re-train for employment and to settle in suitable jobs than those with permanent but stable disabilities. Those for whom full recovery is expected probably need the most intensively organised course of rehabilitation so that there may be the minimum delay, and thus no loss of confidence in the future and no diminution in the will to work, in re-settling them in their old jobs or in new ones. To these four groups must be added those who are disabled through mental illness or mental deficiency, whose special problems are dealt with in paragraphs 288–297 below. Psychological difficulties are also common among the physically disabled, and social problems are apt to occur in any group, especially among those with unstable and chronic disorders.

28. The approach to such very varied human problems as these must obviously be diverse and flexible. Whatever the form of approach, many witnesses before the Committee stressed the essential part that the medical contribution must make in rehabilitation. The British Medical Association in its evidence—which the Committee found outstandingly comprehensive and valuable—pointed out that rehabilitation begins "with the onset of sickness or injury and [continues] throughout treatment until final resettlement in the most suitable work and living conditions is achieved. . . . Only a person who is medically trained can advise the patient with a full understanding of his disability. . . . There must, therefore, be continuous medical supervision of the patient throughout the process of rehabilitation". Putting this analysis in other words, the doctor plays his part in three main spheres—first and most important, in the diagnosis and treatment of the patient; secondly, in assessing residual capacity; and thirdly, in supervising or otherwise participating in the later stages of rehabilitation and resettlement. Taking this outline of the medical contribution as its starting-point, the Committee in this section of the report examines that contribution in detail and makes recommendations for taking the fullest and most effective advantage of it.

(1) Hospital Treatment

29. The first medical responsibility, that of the diagnosis and treatment of the persons who are the concern of the Committee, rests primarily with the hospital service. The general practitioner may be the first to come in contact with the patient, and may become responsible for the later stages of his treatment or for intermediate stages of it; similarly, some patients, for example the mentally defective child, may first come to light through the school medical officer. But for the most part those in need of rehabilitation, training and resettlement are suffering from sickness or injury of a kind which necessitates reference to and treatment in hospitals as in-patients or out-patients. It is therefore the hospital service that must first be considered in this context.

30. Hospital and specialist services in Great Britain are provided under Part II of the National Health Service Act, 1946, and of the National Health Service (Scotland) Act, 1947. They include:—

(*a*) Hospitals and clinics of every type for in-patients and out-patients, viz. general and special hospitals, mental and mental deficiency hospitals, sanatoria, rehabilitation centres, convalescent homes, physiotherapy and occupational therapy departments, etc.

(*b*) The provision of various kinds of appliances (e.g. artificial limbs, surgical boots, hearing aids and wheel chairs) for those who need them.

The statutory duty of providing these services rests on the Minister of Health and the Secretary of State for Scotland, but the task of local administration is carried out by voluntary bodies appointed for the purpose. Hospitals (other than teaching hospitals in England and Wales) are administered by some 390 hospital management committees (some 80 boards of management in Scotland), each responsible for one hospital or (more usually) a group of hospitals. The scope and content of the hospital services to be provided is determined by regional hospital boards (14 in England and Wales and 5 in Scotland), each responsible to the appropriate Minister for planning and administering the services of a regional hospital area. In England and Wales hospitals associated with university medical or dental schools or post-graduate institutes are designated as teaching hospitals and are administered by 36 boards of governors directly responsible to the Minister of Health.

31. Since the introduction of the National Health Service in July, 1948, all the facilities mentioned in the previous paragraph have constituted an integral part of the hospital service available to everybody in this country. There is, therefore, no distinction that can properly be drawn between the hospital services provided for the " disabled " and those provided for patients generally. Indeed, the primary objective of the hospital services is to treat the patient so as to leave no further problem of training or resettlement; and although the actual numbers of those who continue to suffer from some permanent disability are considerable, they represent only a small proportion of those discharged from hospital treatment. In the widest sense, therefore, all the normal diagnostic and treatment facilities at hospitals and clinics can properly be described as rehabilitation services, particularly where they are so organised and directed by the medical staff that restoration of function to the fullest possible extent is kept in mind by all concerned from the patient's first consultation or admission until his discharge.

32. There are, however, certain departments commonly regarded as constituting the hospital rehabilitation services because they are particularly directed to the restoration of the functional activity of a particular part of the body or of the patient's general well-being, viz. physiotherapy and remedial exercises, occupational therapy, and social work by almoners and psychiatric social workers. The specialist (frequently in physical medicine), and his assistant medical staff together with these specialised auxiliaries constitute the hospital rehabilitation team.

33. The extent to which these services are required and provided naturally varies according to the type of patient and the type and size of hospital. At one extreme the large " acute " hospital has to meet the needs both of in-patients and out-patients with a wide variety of medical and surgical conditions and, therefore, generally provides the most extensive and highly organised services; at the other, the scope and need of these services at the

isolation hospital is comparatively small. At Appendix D are shown by various types of hospital the numbers of those with the particular services available.

34. Physiotherapy includes massage, electro-therapy, remedial exercises and group exercises, the modern tendency being for the more active forms of treatment to increase at the expense of the former passive forms. Within the National Health Service physiotherapy is available only through the hospital service on the prescription and under the supervision of a specialist, since it is held that only in this way can it be given effectively and economically.

35. Occupational therapy may be either specific or general, the first directed to the restoration of function of a particular organ, the second to mental and physical well-being in general. For the most part it takes the form of handicrafts of various kinds, which provide the stimulus towards recovery that is associated with a creative activity. In the past few years there has been a development in the direction of more purposeful activity more closely related to the normal daily activities of patients at work (for example, in the workshop at Luton and Dunstable Hospital) or in their homes (for example in the model kitchens and living rooms at King's College and Middlesex Hospitals). Of special interest is a convalescent/rehabilitation hospital in Edinburgh—the Astley Ainslie Hospital—established over thirty years ago, where occupational therapy in the lighter crafts has been employed for many years as one of the main methods of rehabilitation for both medical and surgical cases.

36. Social work in the hospital service, by the almoner and the psychiatric social worker (the latter mainly at mental hospitals but also at some general hospitals) is of particular importance in the rehabilitation of the patient, both in providing information for the doctor about the patient's social or industrial background, his problems and their solution during the period of hospital treatment, and in assisting the patient on discharge to adjust himself to any necessary changes in home life or work and to take advantage of welfare and other services provided by other authorities. Almoners frequently have to consider with the patient's employer his needs and abilities on return to work. Where a change of work is needed the disablement resettlement officer must normally be brought in ; but where return to the same employer and in particular the same job is possible the social worker can sometimes make arrangements direct.

37. In addition to these rehabilitation facilities at hospitals generally, there are within the hospital services special residential centres of various types. Convalescent homes are numerous—mainly small in size, providing some medical supervision and nursing but little in the way of organised activity or exercise, and catering for the patient who on the completion of his hospital treatment needs rest and care rather than an intensive course of rehabilitation. There is a small number of rehabilitation centres, such as Garston Manor near Watford, and the Bridge of Earn Hospital near Perth, where, under medical supervision, remedial gymnastics and group exercises are given to resident patients in accordance with a programme laid down for each one on admission. The eight centres for miners, originally established by the Miners' Welfare Commission to meet the needs of miners injured in accidents, constitute a special group of this type with an admirable record of successful rehabilitation and return to work in the mines. These centres have an impressive graded scheme of work therapy, the course concluding with activities approximating as closely as possible in the degree of physical exertion required to the work that the men will have to do when they return

to duty. Similarly, the centre at Belmont Hospital, Sutton, is an example of special facilities for the rehabilitation of patients with industrial and other neuroses.

38. Mention must also be made of the arrangements within the hospital service for the provision of medical and surgical appliances of all kinds. On the prescription of the appropriate specialist a patient can be supplied with any one of a wide range, from elastic hosiery and surgical belts to hearing aids, artificial limbs, wheel chairs and power-propelled tricycles. For the most part these are provided through the hospitals, but limb fitting and the supply of power-propelled tricycles are undertaken at special clinics.

39. The Committee has not regarded as within its ambit—nor has it received evidence on—the adequacy of the facilities provided by the hospital service generally in terms of numbers of hospitals or clinics or beds or staff. It has, however, directed its attention both to the use made of hospital resources generally and to the adequacy of the facilities specially concerned with the rehabilitation of the patient. These questions are discussed in the following paragraphs.

40. Several witnesses emphasised their view that the hospital service could in general carry considerably further the rehabilitation of its patients. The Royal College of Physicians of Edinburgh said that if there were an efficient rehabilitation service within the hospital service this would diminish the need for industrial rehabilitation. This view was shared by the British Association of Physical Medicine. Several recent studies have indicated how far the "acute" general hospital is successful—and unsuccessful—in getting its patients back to work. In "Hospital and Community" (London 1954), Professor T. Ferguson and Dr. A. N. MacPhail of the Department of Public Health at the University of Glasgow give an account of an investigation into the effect of hospital treatment on an unselected group of male patients suffering from acute medical conditions at four hospitals in the West of Scotland. The patients were seen by the physician while still in hospital and, with the co-operation of their family doctors, three months and again two years after leaving hospital. Of the many interesting findings in this study mention need be made of only one or two. Of 548 male patients seen three months after leaving hospital 55·5 per cent. had returned to work, 10·8 per cent. were outside the ordinary age of work and 33·7 per cent. were of working age but had not returned to work. On the second survey two years after they left the hospital 474 of the 548 were seen in their homes. It was then found that 106 or 22 per cent. had still not done any work since leaving hospital and 129 or 27·2 per cent. had been in hospital as in-patients on one or more occasions for further treatment. Medical treatment and hospital rehabilitation are not activities in which infallibility or anything near to it can be expected, and it must be borne in mind that the survey covered medical (and not surgical) patients (e.g. cardiac, bronchitic), whose working capacity is apt to be low and variable. Even so, statistics of this kind show how large is the field for further endeavour.

41. In the Committee's view the key to the full development of rehabilitation in the hospital service is the attitude of the hospital medical staff. Comparatively few patients need special measures of rehabilitation; but all of them benefit from hospital treatment to the fullest extent only where that treatment is conceived and planned from the outset by a doctor who has in mind, all the time, the terminal result and its effect on the patient's working capacity and home life. This approach has been accepted in principle for many years. Its fundamental importance was emphasised by the British Association of Physical Medicine in its evidence to the Committee; and the British Medical

Association urged that " from the very earliest days of the illness consideration should be given to its probable outcome and, whenever possible, the patient and his family should be given an estimate of his prospects . . . The doctor should try to plant in his mind, as soon as may be appropriate, the idea of an early return to work and normal life, or as near to normal life as possible, and this must be maintained and strengthened by every member of the team during the process of rehabilitation."

42. But although the principle of the " rehabilitation approach " to hospital treatment (and to medical treatment generally) is accepted and to some degree applied, both Associations considered that consultants and general practitioners are still slow to consider the rehabilitation needs of their patients, and that doctors still need further education in the scope, nature and potentialities of rehabilitation. The Committee sees no reason to dissent from that view ; and it trusts that all possible steps will be taken by medical schools, and by the medical profession generally, to bring home to doctors their responsibility for leadership in this field. In particular the Committee would commend the organisation of local conferences like those of the British Council for Rehabilitation which have proved so valuable, a greater use of the courses provided at Roffey Park Institute, notably by the staffs of teaching hospitals whose interest in them appears hitherto to have been small ; and the inculcation of the principles of rehabilitation by teachers of medicine as part of the curriculum of the medical students who will be the medical profession of the future. (Further suggestions for the education of general practitioners and others are made later in paragraph 63.)

43. The adequacy of the services provided by hospital departments specially engaged in the rehabilitation of the patient (physiotherapy and remedial exercises, occupational therapy, and social work) is a matter to which the Committee gave consideration without being able to arrive at any precise conclusions. So far as physiotherapy is concerned, it was suggested in evidence that more facilities are needed in rural areas and for home treatment, and that there is a shortage of physiotherapists. It appeared to the Committee that to some extent these suggestions derived from a desire to provide physiotherapy as a palliative or even as a placebo rather than as an essential element in a planned programme of rehabilitation treatment, or from too easy an acceptance of the practice of the unsatisfactorily organised out-patient clinics criticised by the British Medical Association. The change in the trend in many physiotherapy departments from the more passive to the more active forms of treatment is very desirable. If in every department treatment were given which in the Association's words is " intensive, planned for the individual patient and has a background of discipline "—such as the Committee saw at several of the hospitals which it visited—it might well be that attendances, being more purposeful, would be less prolonged and the need for staff to that extent relieved. There seems, however, ground for the conclusion that the development of peripheral clinics to meet the needs of rural areas and the provision of more accommodation for remedial exercises and gymnastics, which have been urged upon hospital boards by the Health Departments, should be undertaken by those boards as their resources permit.

44. Occupational therapy appears to the Committee to have reached a crucial point in its development as an aid to rehabilitation. As already indicated in paragraph 35 above, it took its origin from the provision of handicraft activities of various kinds, partly for the diversion of patients and partly for therapeutic reasons, and in recent years there has, especially for men, been a development away from handicrafts towards more realistic occupations such as carpentry, metal work and the use of machine tools,

undertaken under the supervision of craft instructors or rehabilitation engineers in something more nearly resembling a factory atmosphere. In another direction there has been the development of advice and help—particularly to housewives—on how to live with a disability in the home, if necessary with the help of simple gadgets specially designed for personal and domestic use, such as are provided by the Middlesex Hospital and King's College Hospital. (A more detailed study of appliances and gadgets for the disabled is given in Chapter V.) Both these developments appear to be valuable and encouraging, and the Committee was glad to learn that in reviewing their syllabus of training the occupational therapists have them very much in mind. Diversionary types of occupational therapy will no doubt continue to have a place; but in building up their services and particularly their rehabilitation facilities, hospital boards should, in the Committee's view, pay particular attention to these more recent lines of progress.

45. The therapeutic value of the heavier forms of work throughout a full working day in miners' rehabilitation centres, and in the industrial rehabilitation units described in Chapter III, prompted the Committee to consider the advantages of siting an industrial rehabilitation unit administered by the Ministry of Labour near enough to a hospital rehabilitation department to provide what might be described as a "finishing school" for industrial workers undergoing a course of hospital rehabilitation. Such an industrial rehabilitation unit could offer a closer approximation to ordinary factory conditions than any purely hospital unit could do. The arguments for a development of this kind are discussed in Chapter III.

46. Social work at hospitals undoubtedly has an important part to play in rehabilitation as will have been seen from paragraph 36 above, but there is a shortage both of almoners and of psychiatric social workers. In view of the shortage of social workers it is, however, essential that they should not be employed on duties which can be discharged by others; and there may be room for the employment of less highly qualified assistants to carry out some aspects of hospital social work. A Working Party appointed by the Health Ministers is considering the training and functions of social workers in the local authority health and welfare services, and as their conclusions may affect this question the Committee refrains from making any recommendation.

47. In its evidence to the Committee the British Medical Association accepted the need for convalescent homes of the traditional type for patients discharged from hospital who need primarily rest and good food with some nursing care, and possibly special diets or surgical dressings, with a minimum of medical supervision. But the main emphasis of its evidence was laid on the unsatisfied need for planned convalescence of a more active nature provided either by daily attendance at clinics or by residence at a special centre, and the British Association of Physical Medicine confirmed the need for further facilities of this kind. The Committee accepts the view that expansion of these facilities is desirable, and it has devoted some time to consideration of their scope and nature and of the size of the requirements to be met.

48. The scope and nature of the facilities needed was well brought out by the British Medical Association in their evidence contrasting the intermittent and unsupervised treatment often found in physiotherapy departments where proper organisation and close medical supervision are lacking with the purposeful graduated programme of activity—remedial exercises, gymnastics, recreation and work—designed to restore full function and to re-orient the patient's outlook from that of an invalid to that of a responsible worker.

(The Association was concerned particularly with the industrial worker, but the same principle holds good for the housewife or for anyone else who is faced with the problem of learning to live with a disability.) This is the conception which the Committee has in mind and which it saw translated into action at some of the hospitals visited. The main need appears to be not so much for residential centres as for day centres like the rehabilitation unit at the Luton and Dunstable Hospital. The need for day centres of this kind within the Hospital Service was emphasised to the Committee by the three Royal Medical Corporations in Scotland. The Committee RECOMMENDS that hospital boards generally should review their present arrangements, and should do everything possible to secure any necessary reorganisation along these lines.

49. The Committee found some difficulty in assessing the extent to which additional facilities described in the previous paragraph are required. The British Association of Physical Medicine thought that on the average perhaps 5 per cent. of in-patients needed them, of whom the majority could take advantage of them in hospital out-patient departments, but a small proportion, perhaps 2 per cent., in rural, though not as many in urban areas, would need residential treatment. Even in rural areas the further development of peripheral clinics might reduce the need for residential centres. The existing facilities for planned rehabilitation are not sufficient to provide for these numbers; but until the resources now available have been reviewed and where necessary reorganised, it does not seem possible to arrive at any estimate of the need for expansion. The Committee RECOMMENDS that further developments should take place as the need is revealed by hospital boards in their re-organisation and redeployment of existing resources in staff and in accommodation both for out-patients and in-patients at the convalescent stage.

50. Apart from the supply of power-propelled tricycles, where there were some suggestions of difficulty in obtaining them sufficiently quickly, the Committee received no evidence to suggest that medical and surgical appliances were difficult to obtain.

(2) Assessment of disability: "resettlement clinics"

51. The responsibility of the hospital and its medical staff is not restricted simply to the diagnosis, treatment and rehabilitation of the patient in the manner set out in the preceding paragraphs. If the patient is likely on discharge to be left with some residual disability, the hospital staff has the further responsibility of assessing his probable capacity, of recommending any further measures of rehabilitation or training, and of ensuring that at the earliest possible stage he is put in touch with those who will be able to help him—the disablement resettlement officer on employment and training, the welfare officers of the local authority, and so on. This work of assessment and of close liaison with other agencies for the patient's future well-being is of the first importance.

52. Assessment of capacity is essentially a medical responsibility; liaison with other agencies is primarily the duty of the almoner or the psychiatric social worker. For the great majority of hospital patients no assessment on discharge is required; they can resume normal activity. For the minority it is necessary to determine what work they can do, whether they need to seek new employment with or without previous training, and what assistance they may need in home life. Assessment of working capacity is normally done by the completion by the doctor concerned of a form (D.P.1 or its

variations) which serves to indicate to the disablement resettlement officer the kind of work for which the patient seems fitted. If necessary there may be consultation between the doctor and the disablement resettlement officer. A small number of patients presents special difficulties, and for these in a number of hospitals "resettlement clinics" have been instituted. In their most comprehensive form these are conferences at which the chair is taken by a senior member of the hospital medical staff and those present are the consultant in charge of the case, a general practitioner with knowledge of local industry, the physiotherapist, the occupational therapist, the almoner, and the disablement resettlement officer. In one or two hospitals the local authority welfare officer takes the place of the disablement resettlement officer where the problem is one of social rather than of industrial resettlement. The usual procedure is for the patient's case papers to be considered first, then for the patient to be interviewed, and finally for recommendations for his future to be discussed and agreed.

53. A special enquiry was made for the Committee into the extent to which resettlement clinics are in operation in England and Wales, and it was found that they were held regularly at 89 hospitals (56 general, 22 mental and 11 sanatoria) and occasionally at 168 hospitals (124 general, 37 mental and 7 sanatoria). Their distribution is uneven, and it cannot be assumed that all take precisely the form described in the preceding paragraph.

54. In the Committee's view a proper assessment of the patient's future abilities is fundamental to his satisfactory resettlement whether in industry or at home; but it is by no means easy to achieve. The British Medical Association drew attention to the limited usefulness of completing forms, however carefully devised. The Committee realises that the exchange of written information is an essential element in this work; but it considers that, particularly in the more difficult cases, it must be supplemented by consultation and discussion between the doctor concerned and the disablement resettlement officer (or the welfare officer in non-employment cases). In most instances consultation between the doctor and the disablement resettlement officer or welfare officer should suffice; for the more difficult problems a fuller consideration in a resettlement clinic is necessary.

55. Although, as has been said, resettlement clinics are held in a number of hospitals, it seems clear to the Committee that they have not yet been generally accepted by the hospital service as an integral part of it and as an essential element in the arrangements for rehabilitation and resettlement; their success has depended largely on the enthusiasm of a few individuals. The Committee shares the view of the British Medical Association and the British Association of Physical Medicine that in each major hospital a clinic of this kind should be set up as a normal feature of the hospital's work, meeting regularly, and dealing not only with patients ready for discharge from that hospital, but also with those from neighbouring smaller hospitals and those referred from other sources. Such a clinic is essentially a case conference held to advise on the industrial or social resettlement of patients who present special difficulties. In more detail, it should provide a full assessment of the patient's capacity and limitations in relation both to employment and home life; guidance on which types of work he is likely to be able to undertake and which he should avoid, and which types are likely to be available near his home; guidance also on the further rehabilitation or training he may need; and advice on any other assistance required and how it should be obtained. The persons

present at the case conference should be those who have taken part in his treatment and rehabilitation and those who will have to take responsibility for his future progress. Ideally there would be present the consultant in charge of the patient, and his general practitioner, together with any of the following whose advice may be required: the physiotherapist, the occupational therapist, the almoner or psychiatric social worker, and the disablement resettlement officer, the local authority welfare officer or officer of the National Assistance Board or other workers who have particular knowledge of the patient. It may also be advantageous to arrange for the attendance of a doctor with knowledge of local industry (possibly an appointed factory doctor or industrial medical officer). The chairman should be the consultant in charge of the hospital's rehabilitation services: in this the Committee differs from the view of the British Medical Association which suggested a retired consultant, since the Committee considers it essential for the chairman to be an active member of the hospital staff.

56. Although the majority of patients referred to clinics of this kind will necessarily come from hospitals at the time of their discharge, the Committee agrees with the British Medical Association that the scope of the clinic should not be limited to this group but should extend to the consideration of problem cases referred by general practitioners in the area, and exceptionally (for example, where the patient is not in contact with a medical practitioner) by the disablement resettlement officer or other lay officer. Developments of this sort may prove an effective substitute for Medical Interviewing Committees (see para. 180).

57. The Committee RECOMMENDS that regional hospital boards and boards of governors of teaching hospitals should review their present arrangements for resettlement clinics, and should take steps to ensure that each major hospital sets up a clinic, meeting regularly to deal with cases referred by hospitals, general practitioners or others in an area of convenient size surrounding the hospital.

58. The Committee also wishes to draw attention to the value of resettlement clinics as an educational agent and as a means of promoting close contact between those engaged in this work. This point was emphasised by the British Medical Association, which saw the clinic as "a medium for the education of the medical profession in rehabilitation" as well as "a point of co-ordination for rehabilitation services".

(3) **Administration**

59. The recommendations made for the improvement of the rehabilitation functions of the hospital service will, as has been indicated, require a general survey of existing services. While it is for each regional hospital board and board of governors to decide upon its own machinery for this, it will probably be found convenient to set up a committee or sub-committee for the purpose. It is not suggested that such a committee need be a permanent feature of the board's organisation, but it would serve a useful purpose for some time in fostering any developments decided upon and evaluating their success, and in ensuring that there is adequate co-operation at the hospital level with local authorities and with the local offices of the Ministry of Labour and other government departments. The Committee accordingly RECOMMENDS that regional hospital boards and boards of governors be invited to consider setting up a rehabilitation committee or sub-committee for the purpose of furthering the recommendations in this report relative to the hospital service.

(4) **The role of the general practitioner**

60. At a number of points reference has already been made to the functions of the general practitioner in rehabilitation and resettlement; here the Committee seeks to give a brief sketch of his part as a whole.

61. General medical services in Great Britain are provided under sections 33 to 37 of the National Health Service Act, 1946, and the corresponding sections of the National Health Service (Scotland) Act, 1947. Since July, 1948, every person living in this country has had available to him the services of a general practitioner free of charge. General practitioners enter into contracts for service with executive councils whereby, in accordance with terms of service prescribed by regulation, they take full responsibility for giving their patients all proper and necessary treatment. The services are administered in England and Wales by 138 executive councils, one for each County and County Borough except for eight covering areas of two County or County Boroughs. It follows, therefore, that in England and Wales the areas of executive councils are generally co-terminous with those of local health authorities, since the Councils of County and County Boroughs are the local health authorities for the purpose of providing home nursing, maternity and child welfare services, ambulances, and other health services. The arrangements for the provision of general medical services in Scotland are similar. There are 25 executive councils, each responsible for an area which coincides with the area of one or more local health authorities.

62. The general practitioner is responsible for the treatment of the patient who does not need reference to hospital. His subsequent rehabilitation and resettlement are a measure of the success of the treatment. In this field the general practitioner may enjoy advantages denied to hospital medical staff. Longstanding personal knowledge of the patient may enable him not merely to diagnose and treat effectively but to assess the patient's personality and capabilities very readily and to advise confidently on the future course of action. Local knowledge of industry and personal contacts with employers may enable him to give great help in advising on placing in employment and resettlement. But to serve the patient's interests most effectively, the general practitioner must be able to call on, and be ready to use, the services of the other members of the local team who can help him—the health visitor, the welfare officer, the disablement resettlement officer, and so on. The Committee recognises the many calls on the general practitioner, but it considers (with the British Medical Association) that he can and should undertake fuller responsibility for rehabilitation and resettlement of some of his patients than he normally does now. If he is prepared to do this, the Committee feels sure that he will find not only that the value of his work for his patient is increased, but also that he may be relieved of the continuing burden put on him by patients who are not rehabilitated and resettled in the fullest possible measure.

63. The Committee shares the view of the British Medical Association that at present there is among general practitioners a lack of sufficient knowledge both of the facilities available to them and of the use which can be made of them, and the Committee considers that there is a need for the profession to be educated in this respect. It has paid considerable attention to this point, since the medical profession must inevitably give the lead and set the tone from the beginning of the process of rehabilitation, and if there is ignorance or indifference among the profession the whole process will be vitiated. Reference has already been made in paragraph 42 to the education of consultants and medical students, and in paragraph 58 to the educational possibilities of the resettlement clinic. For the benefit of the general practitioner there are several other measures which the Committee would commend. Visits to industrial rehabilitation units and vocational training centres, and meetings with disablement resettlement officers, would stimulate interest in resettlement and re-employment. The inclusion of rehabilitation among the subjects in the refresher courses provided by universities for general practitioners in the National Health Service would keep their

knowledge in this respect up-to-date, and the provision of general information about rehabilitation in the Handbook for General Medical Practitioners would assist them to make use of it. Finally the provision in each area of a short leaflet for general practitioners setting out the facilities, accommodation and staff available for patients with disabilities—a leaflet which would need to be produced jointly by the hospital and health, welfare and education authorities of the area and the government departments concerned —would give them precise and up-to-date local information. The Committee RECOMMENDS that the Health and Education Departments, the Ministry of Labour and National Service, the Ministry of Pensions and National Insurance and the National Assistance Board should all take such steps as are necessary to provide the profession with the information it needs.

(5) **Regional Medical Service**

64. The Ministry of Health and the Department of Health for Scotland maintain a Regional Medical Service consisting partly of whole-time regional medical officers and partly of part-time medical referees whose main function is to give a second opinion upon the capacity for work of persons referred to them by the Ministry of Pensions and National Insurance, the Ministry of Labour and National Service and the National Assistance Board. The Committee has been informed that it has been the experience of those participating in the Service that a considerable proportion of those referred to them might benefit from some form of rehabilitation, either at a hospital or hospital rehabilitation centre or at an industrial rehabilitation unit of the Ministry of Labour. It is not part of the function of the regional medical officer or medical referee to make arrangements of this kind, but it is desirable that his special knowledge of local rehabilitation facilities and his findings in the particular case should be made available for further action by the person's general practitioner and the government department concerned to secure that any necessary further action will be taken. The Committee accordingly RECOMMENDS that whenever the regional medical officer or medical referee is of opinion that a person referred to him would benefit from rehabilitation facilities of any kind known to him he should include a statement to that effect, with such details as are necessary, in his report.

(6) **Other Medical aspects of rehabilitation and resettlement**

65. In addition to the medical contribution in the hospital service and in general practice, there are a number of respects in which a medical element —in the form of supervision and advice rather than of diagnosis or treatment —is still needed in later stages of rehabilitation and resettlement. These are mentioned in other parts of this report.

CHAPTER III. INDUSTRIAL REHABILITATION

66. In its report the Tomlinson Committee commented that the majority of persons, on the completion of their hospital treatment, are fit and able to take up their previous or some other satisfactory form of employment but a number will be physically or mentally unfit for immediate full-time activity. For these it was suggested that there should be reconditioning courses of physical training and graduated work to enable them to go either direct to employment or to a vocational training course to learn a new occupation. Although the report dealt only with reconditioning following hospital treatment, these facilities were early recognised as being equally valuable for disabled persons not recently discharged from hospitals but still suffering from the effects of disablement, and either unable to undertake work or unable to remain in it for any reasonably long period.

67. The recommendation of the Tomlinson Committee was made effective in the Disabled Persons (Employment) Act, 1944, which empowers the Minister of Labour to " provide or make arrangements for the provision by other persons . . . of industrial rehabilitation courses for disabled persons . . . who, by reason of unfitness arising from injury, disease or deformity, are in need of such facilities in order to render them fit for undertaking employment, or work on their own account ". The facilities are described as those " whereby such persons may, under adequate medical supervision and under circumstances conducive to the restoration of fitness, obtain physical training, exercise and occupation conducive to the restoration thereof ".

(1) Industrial rehabilitation units of the Ministry of Labour

68. The Ministry of Labour has for this purpose set up 15 industrial rehabilitation units throughout the country. They provide courses for patients from hospitals, for patients referred to them by general practitioners and for persons with long-standing disabilities who may no longer be in touch with a hospital or a general practitioner but who come to the notice of the disablement resettlement officer at local employment exchanges because of the difficulty of finding them work. In the ordinary way it is assumed that before admission the rehabilitee has completed his medical treatment, if any ; he is admitted only if he is regarded by the medical officer of the unit as being likely to be fit to take up employment at the end of the rehabilitation course. The aim of the units is to restore the rehabilitee's confidence in his ability to return to work, to toughen him up physically, to assess his capabilities for various kinds of work, and to advise him, where a change of job is desirable, on the choice of a new occupation or on a suitable form of training.

69. Each unit has a number of workshops, a gymnasium, a garden, a schoolroom and accommodation for interviews and for general administration. The workshops are equipped with power-driven machines and a variety of tools and precision instruments. One unit, at Egham, is fully residential ; those at Leicester and Granton (Edinburgh) are partly so ; all the others are non-residential but in conjunction with these suitable lodgings are arranged for rehabilitees who come from a distance. The Egham unit has accommodation for 200 and the others for 100 each. The courses average eight weeks, and may be extended to a maximum of twelve weeks ; they are free, and maintenance and lodging allowances are paid.

70. There is a rehabilitation officer in charge of each unit, and each unit has a part-time medical officer who is usually a local general practitioner with some experience of industrial medicine. The staff also includes an industrial psychologist, a social worker, a remedial gymnast, a chief occupational supervisor, six or seven occupational supervisors, a disablement resettlement officer and ancillary staff. (The staff at Egham is larger.) This staff is responsible for the general administration of the unit, and the chief officers form a team for carrying out one of its most important functions, that of assessment. The objects of assessment are to plan the work of rehabilitation at the unit to fit the needs of each rehabilitee when he is admitted ; to review his progress as he proceeds ; and to advise on his future before he leaves. Those who complete the course are referred, with a full assessment of their abilities and the type of employment most suitable for them, to the local office of the Ministry of Labour either for placing or for vocational training. Follow-up enquiries are made six months after a person has finished his course.

71. The capacity of these 15 units is 1,600 and in the course of a year some 10,000 persons pass through them. All kinds of disabled persons are provided for, including the partially-sighted, but for the blind separate provision is made (see Chapter X 3 (*a*)).

72. Statistics supplied to the Committee give a general indication of the extent of the contribution that the industrial rehabilitation units of the Ministry of Labour have made in fitting men and women for work and directing them towards suitable occupations. The units are well utilised ; they are running at present on the average at about 85 per cent. of capacity, and some of them have waiting lists. An increasing number of persons is referred to them by the medical profession, although places will probably always be required for Ministry of Labour nominees. At present about 70 per cent. of those admitted come from hospital specialists or from general medical practitioners, and the balance consists largely of disabled persons suffering from long-standing disabilities who, in the view of the disablement resettlement officer, would benefit from the course provided. Of the 10,000 admitted in a year, 8,500 complete the course and of this number over 80 per cent. are successfully placed in employment (including some in training), within three months of leaving the unit. The units are thus well established in the rehabilitation field and their record of placings is noteworthy.

73. These results would appear to owe much to the general atmosphere in which the work of the unit is carried out. The rehabilitees are away from the protective atmosphere of the hospital or convalescent home—and in some instances, of their own homes—and are personally responsible for punctuality, regular attendance, and the completion of a full day's work. The machines and tools are of a kind that the rehabilitee will expect to find in a modern industrial shop. A substantial amount of the work done is by way of sub-contract for outside firms and this makes the work more realistic. In the view of some witnesses, perhaps the most effective contribution that the unit makes emanates from the fairly elaborate arrangements for assessment which have been described, providing as they do a systematic study of each rehabilitee at the various stages of his course by the unit staff.

74. The Committee received evidence from many quarters of the value of the work done by the present industrial rehabilitation units, and is in no doubt that they perform a useful and necessary service.

75. The evidence about the usefulness of the work done at the units was accompanied in several instances by comments on the relationship of the units with hospital and specialist services and on the extent to which they are doing more, or less, than they might in the field of what is ordinarily called medical rehabilitation. The Royal College of Physicians of Edinburgh and the British Association of Physical Medicine thought that if hospital rehabilitation facilities were more fully developed there would be less need for industrial rehabilitation of the kind at present provided by the Ministry of Labour. On the other hand, there was general agreement in the medical evidence that the medical element in the administration of industrial rehabilitation units should be strengthened on the ground that although the rehabilitees at these units were supposed to have completed their treatment if they were referred by a hospital or a general practitioner, there might well be residual disabilities which required medical and possibly specialist advice and treatment. There was difference of medical opinion on the question whether the units should admit rehabilitees who had not been certified as fit for work. The Royal College of Physicians of Edinburgh wished all such

persons—including the doubtfully fit cases—to be dealt with by the hospital service. The British Association of Physical Medicine and the British Medical Association, on the other hand, thought that units might open their doors wider than at present. The British Medical Association thought that the industrial rehabilitation unit could, with advantage, take in not only those who had completed medical treatment such as healed fracture cases, but also those who needed continued medical treatment or close medical supervision for particular conditions, e.g., peptic ulcer, diabetes, and chronic bronchitis.

76. These varying points of view prompted the Committee to consider in some detail the general question of the relationship of hospitals to industrial rehabilitation, and from that to formulate conclusions on a balanced development between the two services in the near future, and the best means of improving their functional relationships.

(2) Relationship between hospital and industrial rehabilitation units

77. The substance of the criticism implicit in the evidence received appears to be that the industrial and medical rehabilitation services have not grown up together on a co-ordinated plan, and that this has resulted in unnecessary obstacles to easy co-operation at the day-to-day working level.

78. This separate development of the two services may have been accidental or it may have stemmed from the Tomlinson Report itself. That report made a distinction between medical rehabilitation and post-hospital rehabilitation. Although some possibility of overlapping was foreseen, the report is written on the basis that a line of demarcation can be drawn between them; there are separate chapters on medical rehabilitation and on post-hospital rehabilitation, and recommendations are made at the end under these two separate headings.

79. It emerged clearly in evidence given to the present Committee, however, that it is often difficult to draw a line in the individual case where medical rehabilitation comes to an end and industrial (i.e., non-medical) rehabilitation begins. This emerged not only in the evidence received, but in the course of visits to industrial rehabilitation units and to hospital rehabilitation centres. The evidence of the British Medical Association summed up the matter by saying:—

> "If rehabilitation is to be based upon the patient's individuality, the unity and continuity of the process must be accepted. It is useful for practical purposes to speak of three stages—acute illness, convalescence and resettlement. It must however be recognised that these stages merge into one another. . . . The principle of the indivisibility of rehabilitation invalidates the tendency to distinguish between medical rehabilitation and industrial rehabilitation . . . medical supervision continues to be necessary after active medical treatment has been completed."

80. The Committee accepted it as a fundamental principle, therefore, that the rehabilitation process is to be conceived, not as divided naturally or essentially into definite stages, but as a single process in which the emphasis at the beginning is on the medical aspects, and the emphasis at the end on the work aspects.

81. Where, as is probably necessary, the rehabilitation process is spread over two or more different agencies they must function together so that the continuity of the rehabilitation process is preserved for each rehabilitee. This

does not mean that one doctor will follow the same patient throughout the process. The British Medical Association put the matter thus:—

> "The meaning of the term 'continuous medical supervision' should be understood correctly. What is meant is that the patient is always under the close personal care of the medical practitioner appropriate to the particular stage of rehabilitation whether he be the hospital consultant, the industrial medical officer, or the medical officer of the Industrial Rehabilitation Unit. . . . Confidential medical information about the patient is passed on as one medical practitioner takes over the responsibility from another."

(3) **Future Provision**

82. The application of this principle of continuity to a balanced provision of facilities for hospital and for industrial rehabilitation is a problem on which it is not easy to be very precise. It is clear that there is scope for development on both sides, and the Committee knows of no fundamental obstacles to co-ordinated development so that both types of service can work closely together in the interests of continuity. There appear to be certain factors which point towards a higher degree of priority in the near future for the medical aspect of rehabilitation. The number of persons needing some form of rehabilitation service is greater on the hospital side, yet since the Tomlinson Report was published there has been relatively less development of hospital rehabilitation than of industrial rehabilitation. There is thus, relatively speaking, considerable leeway to be made up on the hospital side, and the Committee RECOMMENDS that the larger share of what can be spared from the national resources for capital development for rehabilitation in the near future should be on that side.

83. It has, however, to be borne in mind that at the present time there are several important and heavily populated areas without industrial rehabilitation units, e.g., Liverpool and certain districts of London, and the Committee RECOMMENDS that additional units should be supplied as soon as possible especially where this can be done relatively inexpensively by the adaptation and equipment of existing premises.

84. The Committee has also reviewed the functional relationship between existing hospital and industrial rehabilitation centres in the light of the principle of the continuity of the rehabilitation process as enunciated above.

85. The first question is whether there is a need for greater flexibility in the allocation of rehabilitees to one service or the other.

86. The Committee accepts the view that the industrial rehabilitation unit should be ready to admit the rehabilitee at as early a stage as is possible and desirable. The Committee has found some misunderstanding about the form of certification required for admission to an industrial rehabilitation unit, it being assumed by some medical witnesses that an entrant must be certified as fit for work before admission and that the removal of this restriction was thus necessary in order to admit persons still in need of some form of medical treatment. This is not so. All that is required is that the man should be regarded by the unit doctor as likely to be fit for work at the end of the rehabilitation course. The general practitioner after discussing the matter with his patient, should get in touch with the local disablement resettlement officer with a view to arranging for the man to be considered for admission to the course. Administrative arrangements provide that sickness benefit is superseded by the payment of allowances as soon as the course is started. The Committee is satisfied that the existing arrangements of the Ministry of Labour for admission are sufficiently flexible to permit

entry at varying stages of recovery. The Committee accordingly trusts that removal of any misconception about the eligibility on medical grounds for admission will lead to more industrial workers being sent to these units at an earlier stage of their recovery.

87. The parallel to this desirable trend at the industrial rehabilitation unit is the extension of the rehabilitation facilities of the hospital service to take in a disabled person who has been unemployed for some time, who has not been under hospital care, but for whom hospital rehabilitation is desirable. Such cases would normally be referred by the Ministry of Labour through the person's general medical practitioner to the hospital resettlement clinic, and it would be for this clinic to assess the need for hospital rehabilitation in each case. Recommendations on the development of resettlement clinics are given in Chapter II, paras. 51–58.

88. As already mentioned, much of the medical evidence received stressed the need for increasing the medical content of the industrial rehabilitation service. The representatives of the National Advisory Council on the Employment of the Disabled emphasised the importance of ensuring that the industrial character of the units, which had all along contributed to their success, should be maintained. The Committee sees no inconsistency in these two views; it merely records its opinion that if more rehabilitees are to be admitted to industrial rehabilitation units at earlier stages of their recovery an increased medical provision should be made. The part-time medical officer attached to the unit may have to give more time to the assessment and treatment of those taking the course and to liaison with hospitals and general medical practitioners, and the Committee RECOMMENDS that the Ministry of Labour should provide for the additional medical sessions required.

89. A valuable augmentation of medical services in the industrial rehabilitation units could be effected by the provision of the specialist services (including psychiatry) when the unit medical officer considers that these are necessary for particular patients. In some cases this might mean a regular weekly visit; in others, a visit as required. Alternatively it might in some cases be more convenient and satisfactory to refer the rehabilitee to a hospital out-patient department. The Committee RECOMMENDS that regional hospital boards should provide specialist services on the above basis to industrial rehabilitation units and that they should do so wherever possible by arranging for a particular hospital to be linked with the industrial rehabilitation unit concerned, as was indeed suggested by the Tomlinson Committee in its report. A linking arrangement of this sort will be particularly useful where the hospital itself has a well developed rehabilitation department.

90. These proposals for bringing industrial rehabilitation units into closer functional relationship with the hospital are intended, in the first instance, for existing units and hospitals, but are of equal importance in new developments. The Committee RECOMMENDS that all new developments for industrial rehabilitation units or for hospital rehabilitation centres should be planned with the facilities and needs of the other service in mind. In particular, it is essential to provide for easy interchange of rehabilitees between the one service and the other and to ensure that specialist services can be made available at the industrial rehabilitation unit.

(4) Proposal for a Comprehensive Rehabilitation and Assessment Centre

91. The Committee has considered whether the basic principle of the continuity of the rehabilitation process leads to a need for the bringing together of hospital rehabilitation departments and industrial rehabilitation units on the same site. Opinions differ on this point. Some see an advantage

in having the stages of hospital treatment and industrial rehabilitation clearly distinguished by keeping the activities separate throughout, others believe that a close conjunction of the two types of establishment would not only symbolise the basic principle of continuity in physical terms but would also facilitate its realisation.

92. Such a combined centre would be associated with, and located as closely as possible to, a general hospital but would not be a part of it. It would provide within its boundaries a variety of services. The rehabilitation units would include an occupational workshop which would be part of the hospital service, and an industrial workshop which would be part of the industrial rehabilitation services of the Ministry of Labour. Two adjacent establishments of this kind would make it easy to allocate rehabilitees to the type of therapeutic activity most suitable for them. It would be particularly useful, as was suggested in Chapter II, to have the heavier forms of industrial rehabilitation at hand for manual workers who have been undergoing a course of hospital treatment. Specialist services would be readily available, and physiotherapy and remedial gymnastics would be provided by the hospital as common services. There would also be a common service of assessment provided jointly—and perhaps with some consequent saving of staff—by the hospital service and by the Ministry of Labour. Such an assessment service, housed in adjacent accommodation of its own, would be concerned with selecting rehabilitees, prescribing the right programme for them, keeping a watch over their progress and making a final recommendation as to their future. It would probably be most convenient to organise these varied services for daily attendances, but a hostel might be useful for those coming from a distance, even if it were only for assessment. An organisation conceived on this broad basis might be described as a comprehensive rehabilitation and assessment centre.

93. A comprehensive centre of this kind is probably the logical development of the principle of the continuity of the rehabilitation process. The Committee is not aware of any existing unit that answers to the full conception of such a centre as outlined above, and foresees difficulties, for example of siting, in the development of such centres. The conception, however, seems to the Committee to be soundly based, and worthy of experiment in areas where both hospital and industrial rehabilitation facilities are inadequate or require fuller co-ordination and where the remedy lies in new building rather than in the adaptation of existing premises. The Committee accordingly RECOMMENDS that a proportion of any additional resources set aside for rehabilitation services should be devoted to building two or three comprehensive rehabilitation and assessment centres of the kind described above.

(5) Rehabilitation in Industry

94. The advantages of introducing industrial conditions as faithfully as possible into the later stages of rehabilitation have been mentioned in the discussion of industrial rehabilitation units. It is of special advantage to a disabled person if this stage of his rehabilitation can be carried out upon suitable production work in his employer's establishment; his sense of personal satisfaction and reassurance at returning so early to a familiar environment and something akin to his usual work must in itself be of great rehabilitative value. A few large firms have set up special rehabilitation workshops, usually inside their main works, to which an employee is encouraged to return when he is regarded as medically fit to do some kind of work, although not able to take up his former occupation. Here, under medical oversight, and under the supervision of an engineer selected for his skill and ingenuity in providing and adapting suitable equipment and machinery, a disabled person

can have his physical capacity developed and his confidence restored whilst engaged on productive work. The Committee received evidence that such rehabilitation workshops enabled a sick or injured worker to return to work much sooner than would otherwise have been possible. Where a change of occupation is found to be necessary, he can be initiated into the basic movements required for it. It is clear that these facilities can be given only by large firms where the flow of disabled workers will be sufficient to justify the setting up of a special workshop and where there is a sufficient variety of work to be undertaken.

95. The Committee had the advantage of visiting one of these rehabilitation workshops and it regards projects of this kind as wholly admirable. At the moment they are restricted to a handful of firms, and the Committee hopes that other large firms will venture into this useful field. It is important that any rehabilitation workshops within industry should have a link with the local hospital rehabilitation department so as to ensure continuity of treatment.

96. In smaller firms this gradual approach by means of work exercises to employment under normal conditions is unlikely to be practicable in any formal way, and in such circumstances the gap may well be filled by a nearby industrial rehabilitation unit, particularly where serious disabilities are involved.

97. The suggestion was put to the Committee that smaller firms would take back their disabled workers earlier on a part-time basis if some inducement were offered in the form of continuing payment of sickness benefit proportionate to the reduced hours of working. For example, a worker employed for three-quarters of his time would get that proportion of his wages, and one-quarter of his sickness benefit. Because of the difficulties of assessing the degree of working capacity, and cost of administering such a scheme, the emphasis on the number of hours worked to the disregard of other conditions, and the difficulty of providing adequate medical supervision, the Committee is not able to accept the suggestion, which it understands is not favoured by either side of industry.

98. Whether or not rehabilitation of these more formal types is provided, employers can—and in many cases do—take steps so to modify the conditions or tempo of employment as to enable the disabled person on returning to employment after illness or injury to accustom himself more gradually to industrial conditions, and this can be a substantial factor in the successful rehabilitation of the worker.

CHAPTER IV. WELFARE SERVICES FOR THE DISABLED

99. Whether a disabled person has lately left hospital or has been living with his disability for some time, there are directions in which he is likely to need help if the disability prevents his taking some part in home or community activities. This help may be forthcoming from members of his own household, friends and neighbours, or other voluntary sources, and it will sometimes be all that is necessary to fill the void caused by incapacity and the restriction on activity and interests. But frequently something more is required if the disabled person is to feel that he is playing as full a part in life as he is capable of enjoying, and this further need will be particularly felt by those who are not engaged in some form of outside employment that would be likely in itself to provide the benefits of companionship, independence and well being.

100. For many disabled persons therefore, and particularly for those not at work, some more comprehensive welfare provision of a statutory character may be necessary. This is provided in the National Assistance Act, 1948.

101. In a circular on the National Assistance Act which was issued to local authorities in June, 1948, the Minister of Health said: "The objects which Parliament had in mind will not be achieved unless those responsible for the administration of the new Act have the will and the vision fully to seize the opportunities it has given them to substitute a modern welfare service for one which had perforce to be based on outmoded legislation and for the relief of destitution". The Committee has examined in the light of this guidance the welfare services for the disabled provided by local authorities, particularly from the point of view of their possible development, and has had in mind that the services for the blind, being of much longer standing, are already highly developed, so that they could be regarded as a ready-made yardstick.

102. Section 29 of the National Assistance Act, 1948, empowers County and County Borough Councils in England and Wales and their equivalents in Scotland to make arrangements for promoting the welfare of persons who are blind, deaf or dumb and others who are substantially and permanently handicapped by illness, injury or congenital deformity. Local authorities exercise their functions in accordance with schemes approved by the Minister of Health or Secretary of State for Scotland. Local authorities had a duty to provide welfare services for the blind under the Blind Persons Acts, 1920 and 1938. These Acts were repealed by the National Assistance Act, 1948, but the duty was continued under it. The schemes embrace arrangements for the medical examination and certification of applicants for admission to the registers of the blind; the registration of those persons duly certified as blind; the provision of a home teaching service by qualified home teachers; the provision of sheltered employment in special workshops and through home workers' schemes; assistance in securing employment in open industry; arrangements for promoting the general social welfare of blind persons including assistance in the disposal of articles made by blind persons in their own homes and elsewhere, the establishment and maintenance of social clubs, and the provision of library facilities, etc.

103. The duties of home teachers of the blind include discovering blind persons and ascertaining their needs; visiting blind persons in their homes or elsewhere; teaching them, wherever practicable, to read embossed literature; instructing them in simple pastime occupations in their homes or elsewhere and in methods of overcoming the effects of their disabilities; generally assisting in promoting their welfare; advising blind persons of all available social services; paying particular attention to those blind persons who are also suffering from some other form of handicap, the nature of which is such as to increase the disability of blindness; and organising social centres and classes. (Chapter X, paragraphs 265–273 deal more fully with the blind.)

104. From the foregoing, it is clear that the services for blind persons are very comprehensive. The services for the partially sighted in general follow the same pattern. Probably because of the nature of the disability the blind stand out as a class which for many years has benefited from the ministrations of well-organised voluntary bodies. The blind were also the first to be assisted specifically by legislation and for many years they have been and still are more fully provided for than any other class of disabled.

105. Guidance to local authorities on the provision of welfare services for other classes of handicapped persons was issued by the Minister of Health in Circular 32/51 dated 28th August, 1951, and by the Secretary of State for

Scotland in Circular 14/51 dated 21st April, 1951. In these circulars, local authorities were invited to submit schemes to the respective Ministers for approval and model schemes were sent to local authorities by way of guidance.

(1) Action by Local Authorities

106. The provision by local authorities of welfare services for disabled persons other than the blind was in 1948 a new departure. The Committee was informed that at 30th June, 1956, 110 out of 146 local authorities in England and Wales had made schemes for services, but development has not yet reached the stage at which the authorities are involved in substantial expenditure. The total amount spent by local authorities in England and Wales for the year ending 31st March, 1955, on services for the disabled other than the blind and partially sighted was only some £250,000 as compared with £2·4 millions spent in the same period on the blind and partially sighted. Comparable figures for expenditure in Scotland are £25,500 and £170,000. Many authorities, including a number who have not yet made schemes, began by reviewing the existing situation in regard to the disabled persons in their area, both to give them a preliminary idea of the services likely to be required and to form a basis on which to start compiling their registers of the handicapped. They now have the task of building up their services, in particular those concerned with social activities for the handicapped (e.g., the establishment of social clubs) and with providing some form of occupation for them such as handicrafts either at the clubs or in their own homes. It is clear that only the fringes of the field have yet been touched. The Act gives local authorities very wide permissive powers to make provision for the welfare of disabled persons, and on the evidence received there is no doubt that there is a need for fuller and better provision and scope for considerable development.

(2) Demarcation of the Welfare Field

107. The Committee has considered what main needs by way of welfare, as distinct from specifically medical aids, a disabled person is likely to have. Obviously, the particular kind of service which he will require will vary according to the nature of his handicap and the degree of personal adjustment which he has achieved and is capable of achieving. In every case the chief object of a welfare service must be to ensure that sufficient aid is given to any handicapped person requiring help to enable him, thus aided, to have some share in the life of the community. The handicapped person should be enabled not just to live in the community but be able to contribute to it by work, if that be possible, and by playing a part in whatever social life exists around him. In particular, his self-confidence and self respect must be restored or developed. One of the most valuable services that can be rendered to him is to implant in him a feeling that he matters and that his well-being is of concern to the community. The purpose of the local authority services is to set up machinery to ascertain the number of those who are in need so as to be able both to estimate the extent to which provision is necessary and then to identify and keep in contact with the individual. Then there must be instruction on the methods of overcoming the effects of particular disabilities. There should be guidance given on the various means which exist to help the physically handicapped in their everyday life with dressing, the toilet, feeding and so forth. For some the most material help which can be given to them will be the provision of living accommodation, and this —in the words of the circular issued by the Minister of Heath and mentioned above—should " be a substitute for a normal home and must meet all reasonable needs of the residents ". Those who are able to work should be guided

to the proper agencies through which remunerative employment may be obtained. For others, useful occupation in centres or at home is needed. This will also include assistance in the marketing of the products so made. For all, recreational and social facilities must be available and for those who are without friends or relatives of their own, there must be the means to encourage them to make an effort to take part in the life of the community.

108. It may be useful at this point to offer some general remarks designed to assist in the proper demarcation of the welfare field. Some of those entering this field will be found in their own homes where they have been for a long period under the care of their family doctor though a proportion may rarely have sought medical advice. Others will previously have been hospital patients but the great majority of those who are capable of work should, on discharge from hospital, be able to pass directly to the resettlement service provided by the Ministry of Labour. The responsibilities of the local authorities may therefore be summed up as follows :—

(*a*) to meet the social and occupational needs of those disabled who do not come within the employment field ; and

(*b*) simultaneously to cater as far as may be required for the social needs of the disabled in the employment field.

109. For hospital patients the initial training in daily activities and the assessment of welfare needs should commence in hospital. The progression visualised is for hospitals to start the training and for local authorities to complete the process either in a centre of their own, outside the hospital, or in the home of the disabled person. The point at which the patient should be discharged from hospital and his training carried on and finished by the local authority welfare service is as soon as he becomes fit to pass under the care of his general practitioner for his general medical needs.

(3) **Co-operation with other services**

(a) *Hospital*

110. The Committee thinks that as the welfare services develop more should be done to provide close co-operation between the local welfare authorities and the hospitals. There is room for development broadly on lines similar to those already in use for promoting the co-operation between the disablement resettlement officer and the hospital. A suitable officer might be nominated by the local authority to visit the hospital regularly and attend conferences designed to assess the welfare needs of particular patients and to give guidance in specially difficult cases. The advantage thereby gained would be two-fold. The welfare authority would from the outset gain a deeper insight into the disabled person's limitations and potentialities ; the hospital would have the benefit of expert advice on the help which could be given to their patient through the social welfare services.

111. From time to time officers of welfare authorities may consider that expert and special guidance is needed in difficult cases encountered in their work. The hospital resettlement clinic is clearly a likely source for such guidance. In cases of this kind the general practitioner should provide the link with the hospital and when approached should be ready to refer a patient to a resettlement clinic at a hospital.

(b) *General Practitioner*

112. Another very important requirement is that there should be proper arrangements to ensure that the medical needs of persons cared for by the welfare services are looked after. In other words, there must always be in the true sense continuity of medical care, but particularly when a

person enters the welfare field on discharge from hospital. The proper agency for attending to these medical needs is the general practitioner and means for providing a link between the general practitioner and the hospital already exist. Hospitals have been advised by the Ministry of Health that in every case the general practitioner should be informed at once when a patient is discharged and a full report and advice sent to him within a few days at the most. Where the local health authority services (e.g., home nursing, special equipment for use in the home) are required, information about the discharge or imminent discharge of patients should, with the patient's agreement, be given to the Medical Officer of Health. The Committee understands that although reports are always sent by hospitals when patients are discharged, they are not always sent promptly so that much of their value is lost. It accordingly RECOMMENDS that hospitals should make it their invariable rule to send reports of the imminent discharge of patients without any delay. The welfare authority for their part should always ensure that the general practitioner is consulted as necessary as to whether, from the medical point of view, the welfare services being provided for a disabled person (whether or not he has been a hospital case), are appropriate. Officers of the local authority visiting a disabled person at home should form part of a domiciliary team under the clinical leadership of the general practitioner with whom all members of the team should be in personal contact in order to bring the maximum benefit to the disabled person living in his own home.

(c) *Other Services*

113. In addition to co-operation between the welfare departments of the local authorities on the one hand and the hospitals and general practitioners on the other, there are other fields in which close co-operation is equally important. It is essential that the health and welfare departments within the same local authority work in the closest co-operation, particularly where the two departments are interested in the same disabled person and where medical oversight is still needed. Welfare facilities should, therefore, be closely linked with arrangements for after-care. There must also be co-operation with the officers of the National Assistance Board and of the Ministry of Pensions and National Insurance to ensure that the social benefits of the various services are made available quickly and effectively.

(4) Provision for Welfare

114. There are certain aspects of welfare not yet catered for in which present facilities fall short of need.

(a) *Occupational and Social Centres*

115. As has been noted above (paragraph 106) local authorities are already beginning to provide centres for occupational and social purposes either directly or through voluntary organisations. These should include as one of their main objects the meeting of the needs of disabled persons outside the employment field. Local authorities should do everything possible to set up, or to encourage the formation of, day clubs or centres where the severely disabled can not only find social companionship together with some diversionary occupation but will also be provided with training in the techniques of overcoming their handicap and in performing their daily activities. Not the least advantage of such centres would be to afford some relief to fit members of the disabled person's household. To give an example: one important job of the day centres will be to provide for the training (or the completion of training) of disabled housewives in doing their daily domestic tasks in the kitchen and about the home. It should

often be possible to use the day centre for the organisation and distribution of home work for those who are house-bound. This is a field in which considerable use might be made of voluntary effort.

(b) *Sheltered Employment and Homework*

116. At present the permissive services which can be provided by local authorities under Section 29 of the National Assistance Act overlap in some respects the services which can be provided by the Ministry of Labour for those in the employment field. This overlapping is mainly in the field of sheltered employment and recommendations in this field will be found in Chapter VIII. The provision of home occupation is also substantially a welfare problem, but for convenience it has been considered in Chapter IX which covers all categories of homeworking schemes.

(c) *Provision of Gadgets. Aids, etc.*

117. Local authorities which have adopted schemes based on the outline scheme issued by the Ministry of Health and the Secretary of State have power to provide at their discretion gadgets and similar aids for assisting the disabled in the daily tasks of life (e.g., aids in dressing, washing, eating, stoking the fire, etc.). There was some evidence in favour of an extension of the schedule of appliances which can be provided free under the National Health Service Acts but the Committee is opposed to this. Many useful gadgets are comparatively simple devices which can be fashioned by a handy-man amongst the disabled persons' relatives or even by the disabled themselves in the occupational therapy department of a hospital or at a local authority's recreation centre. The Committee attaches importance to this element of self-help by the disabled and those responsible for caring for them. To the extent that necessary aids are not or cannot be provided in this way it is right that provision of them should rest with the welfare authority. This matter is dealt with more fully in Chapter V.

118. Welfare authorities also have power to make necessary adaptations in the homes of the disabled, and these powers have been exercised in a number of cases. In this connection all those responsible for new local authority housing schemes should bear in mind the needs of the disabled. Some of the accommodation should be specially designed without steps and with wider doors to allow the passage of wheel chairs.

(d) *Hostel accommodation*

119. The need for additional hostel accommodation for the disabled was stressed in a great deal of the evidence submitted. These hostels are needed for two purposes: as short-stay hostels for disabled persons leaving hospital but not yet fit for ordinary living accommodation; and as permanent hostels or homes for the more dependent disabled. Local authorities have a duty under Section 21 of the National Assistance Act, 1948, to provide residential accommodation for persons in need of care and attention not otherwise available to them. The Committee understands that this would cover provision of both the types of hostel mentioned above. In the hostels so far provided under the National Assistance Act local authorities have tended for obvious and understandable reasons to concentrate on providing accommodation for permanent residents. It appears that a stage has now been reached where they could with advantage devote some of their resources to providing short-stay hostels. In the case of certain disabilities such as tuberculosis and mental deficiency they would need, before doing so, to consider their powers as local health authorities.

120. The short-stay hostel would be designed primarily to provide accommodation for the hospital patient who is ready for discharge, in that he no

longer needs the full medical and nursing resources of the hospital but has no home to which he can go. He would be provided with accommodation and board so far as he needs them, with the intention that these facilities would afford a breathing space while he found some suitable permanent home. They would also be of value to some patients from mental hospitals who are sufficiently recovered to take a course at an industrial rehabilitation unit, but who would experience great difficulty in getting suitable accommodation whilst attending the course. (See also Chapter X.) Such hostels should go some way to assist hospitals which quite often cannot admit in-patients simply because beds are occupied by people who cannot be discharged because of social, not medical obstacles. These hostels would also accommodate other disabled persons who for a short time were unable to live in their own homes as, for instance, when the relative or friend on whom they were dependent was ill or away on holiday or business. There is always a tendency as time goes on for facilities intended for short-stay cases to be taken up for permanent occupation to the exclusion of persons who could benefit transitionally. An essential part of the arrangements for providing short-stay hostels would be the inclusion of machinery to transfer into permanent hostel accommodation disabled persons who cannot progress quickly into ordinary living accommodation.

(5) **Compilation of Registers**

121. Where a local authority has adopted a scheme for the welfare of handicapped persons it becomes mandatory on it to compile a register of handicapped persons who apply for assistance under the scheme. General guidance to authorities on the information to be included in the registers was given in Ministry of Health Circular 32/51 (and D.H.S. Circular 14/51). Local authority registers may contain the names of some disabled persons in the employment field who will also be registered with the Ministry of Labour (see Chapter VI, paragraph 154) but the majority of those on the registers are likely to be severely disabled persons not within the gainful employment field. The purpose of these registers is to provide the authorities with relevant information about the persons likely to need their services and to give them an indication of the size and nature of the problem. The registers provide the only effective machinery for enabling the authority to find and keep in touch with the individual. The phrase "substantially and permanently handicapped" is not defined in the National Assistance Act, and the Committee agrees that no rigid formula or definition of a handicapped person for local authority registration purposes is desirable. There may thus be some divergence in different areas in the degree of disablement qualifying persons for inclusion on the register and because of this statistics of the various local authorities' registers may not be comparable, at least in the initial stages of uneven development.

122. Some of the evidence suggested that registers kept by the Ministry of Labour and local authorities should be combined. Special registers compiled for specific purposes are clearly necessary; accordingly, the Committee does not think that the existing registers should be combined, although co-operation between those concerned with the separate registers is essential and should be fostered. Interchange of information whilst most desirable should not take place without the consent of the person concerned. All authorities should do their best to secure this consent, so as to facilitate the interchange of valuable information. This principle is already well recognised and provision is commonly made for its observance.

123. Other evidence suggested that comprehensive and compulsory registration schemes for all disabled persons were desirable. It is the Committee's

view that registration should not be compulsory upon the disabled: it should be the result of a voluntary application by a disabled person. On the other hand, because the ascertainment of the whereabouts and needs of disabled persons is a most important function, local authorities should do all they can, in close co-operation with Government Departments and voluntary organisations, to seek out those they can help and to make known to them the facilities available.

(6) **Finance**

124. So far, this chapter has been concerned mainly in determining where the responsibility for the provision of services lies and recommending the type of development which is desirable. In each of these recommendations financial implications are of paramount importance. With the exception of services for the blind, most of the services in the social welfare field are only just developing or starting with a few pilot schemes. Since local authorities were first invited in 1951 to submit for approval schemes for the welfare of handicapped persons, there has been, and indeed continues to be, a general pressure for economy in their services and their expenditure. This must have retarded the development of these services. Nevertheless, the Committee believes that more would have been done by local authorities in this field if it had not been the case that most of the services which they can provide attract no grant from central funds towards the considerable cost which would be involved. It seems anomalous that, for example, an occupational therapy department in a hospital should be financed completely from Exchequer funds whereas an occupational service provided by a welfare authority at a recreational and occupational centre attracts no direct Exchequer grant whatever. Developments in the welfare field can only take place gradually, having due regard to the nation's ability to pay for the services, but the Committee is satisfied that the existing state of affairs discourages and retards developments which are essential. It therefore RECOMMENDS that local authorities should be grant-aided by the Exchequer in their expenditure on services provided by them under Section 29 of the National Assistance Act. Any such grant should be available without distinction between the type of disabled person or of service concerned, but the rate of the grant would need to be calculated having regard to the extent to which services have already been provided in some fields.

125. It has been exceedingly difficult to make a reliable estimate of the probable cost of developing a full welfare service for all disabled persons. At the present time development is uneven, the size of the problem is not accurately known, and no authority as yet provides all the services recommended in previous paragraphs. The Committee has, therefore, sought to deduce from the current expenditure on the welfare of the blind, what might be the expenditure were a service of comparable scope provided for all the classes of the handicapped. For the year ended 31st March, 1955, local authorities in England and Wales spent £2·4 million gross on welfare services for the blind and partially sighted. The number of registered blind or partially sighted persons at that time was about 110,000, so that expenditure was at the rate of £22 a head. On the 1st January, 1956, the number of handicapped persons of the general classes on the registers of local authorities in England and Wales was approximately 47,000. This figure cannot be taken as representing the total likely to need the services, because registration is not yet complete and some authorities have no schemes. If the incidence of substantial and permanent handicapped be taken at a rate of 3 per 1,000 of population, the number of persons requiring the services would be of the order of 140,000. If the cost of the service for this were comparable

with that for the blind the cost would be about £3·2 million a year. In addition, on local authorities' registers there were 26,000 persons who are deaf or hard of hearing. Registration of those who are totally deaf appears to be reasonably well advanced. Furthermore, the demand for welfare services of the hard of hearing has not been great, does not appear likely markedly to increase, and in any event neither the deaf nor the hard of hearing require a full range of services comparable to the blind or the other substantially handicapped. It is therefore suggested that some £300,000 a year might represent the cost of the services for the deaf. The total, therefore, for the blind, the other classes of the handicapped and the deaf if a full service were provided might be of the order of £6 million a year and on a comparable basis, £600,000 a year in Scotland. As these figures are compiled on the basis of possibly incorrect assumptions they must be treated with reserve. It should be noted that there is a hidden subvention in the services to the blind arising from the various services given voluntarily. Unless similar help were forthcoming towards the services for the other classes of handicapped persons, the cost of the service might be more than the figures suggested. Even so, this cost would rise gradually, because the services themselves would inevitably develop slowly. While there would be some economic return for the expenditure (e.g., enabling an able-bodied member of the disabled person's family to go out to work during the day instead of being tied to his care) it must be recognised that the main expenditure would be incurred in providing a fuller life for severely handicapped members of the community.

CHAPTER V. APPLIANCES AND OTHER AIDS FOR THE DISABLED

126. Reference has been made in the preceding chapter to aids of various kinds, whether these be of the simple and personal kind or those involving structural or other changes in living accommodation. In the Committee's view it is important that gadgets or aids should be kept in their proper perspective and be brought into use only when other more direct methods have been tried to minimise the expenditure of effort and the avoidance of fatigue—for example by doing things in a different way because of the disability. None the less there is undoubtedly a place for the well thought out aid to meet a need which cannot be met in other ways and to enable the disabled person to manage his life or carry out his work with a growing sense of competence and self-reliance.

127. The Committee has received some interesting evidence about recent developments in appliances and gadgets specially designed for the disabled and, in particular, for those who are permanently crippled. Research and development have been undertaken in a number of hospitals and several voluntary organisations have been active in this field. The Ministry of Labour has also developed and made a number of appliances and aids at their government training centres and industrial rehabilitation units. Some of the gadgets most recently devised are very ingenious, and public exhibition of a number of them has been organised by the British Red Cross Society and the Central Council for the Care of Cripples in various parts of the country. The Central Council and the National Association for the Paralysed, in their evidence to the Committee, drew attention to illustrated booklets which they had published giving information about how to buy or make a wide range of appliances and gadgets for disabled people. There is ample evidence that these aids are of the greatest value in helping disabled people to become more independent of their relatives and fellow

workers in the ordinary activities of daily life. The Committee has accordingly taken the opportunity to review the general question of the provision of appliances for the disabled.

128. Appliances for the disabled (other than those specially for the blind) can be classified in six main groups:—

(a) *Medical and surgical appliances and aids to mobility.* These are at present supplied through the Hospital Service and through the General Pharmaceutical Services. This group includes artificial limbs, crutches, surgical footwear, invalid chairs and motor-propelled tricycles.

(b) *Aids to home nursing.* These can be supplied by local health authorities. This group includes bed rests, air rings, etc.

(c) *Personal aids for dressing, toilet and eating.* These consist mainly of adaptations to articles in daily use. The adaptations are of several types, and include long handles and thick handles. The long handles are usually made of plastic material and are designed to assist those with stiff joints. The thick handles are intended for those who have difficulty in bending the fingers sufficiently to take a firm grasp of a thin object. The aids for dressing include long-handled shoe-horns and a long-handled stocking "puller-on". The toilet articles include long- and thick-handled hair brushes, tooth-brushes, sponge-holders and safety razors; and a spanner-like tool for turning on a water tap. Aids for eating include long- and thick-handled knives, forks and spoons. In addition there are special adaptations for many of these articles for the use of amputees. Most of these aids can be improvised but some of them have been manufactured for sale to the public.

(d) *Aids to household activities.* These include long-handled and thick-handled kitchen tools, long-handled wooden pliers for lifting articles from the floor or from high shelves, door knob turners and tap turners for persons with a poor grip and gadgets to assist in cutting bread and peeling potatoes. Again most of these can be improvised, but some have been manufactured for sale.

(e) *Aids to industrial activities.* The design of attachments to artificial limbs and research into new devices is constantly being undertaken by the Hospital Limb Service in order to enable workers to carry out particular processes in the course of their daily work. Other appliances can be made to compensate for deformities and muscular weakness.

(f) *Aids to recreation.* These include playing-card holders, book-rests, page turners, and gadgets to assist writing, knitting, mending, painting and other crafts.

129. From the evidence received, the Committee has no suggestion to make as to the range of the articles in the first two groups, but believes that there are many disabled persons who would benefit from aids in the remaining groups.

130. Personal and household articles can be adapted by any handyman with a little ingenuity and the Committee welcomes the service of advice in this matter which can be had from the three voluntary organisations mentioned. Not every disabled person, however, has a handyman at his elbow, and the question arises whether there is a case for providing appliances of this type, with appropriate charges, through some official source. The Committee notes that the Ministry of Labour has a working arrangement with the British Red Cross Society to produce at its industrial

rehabilitation units various domestic aids which are sold and distributed by the Society for little more than the cost of the materials. It has also seen that at two or three hospitals a small section has been set aside under the charge of an occupational therapist to which disabled housewives are brought in for a day or two with the general object of rehabilitating them for the ordinary business of personal hygiene and household activity. As part of this rehabilitation process they are supplied with personal and household aids of the type described above, these being selected for their particular disabilities, and some training being given in their use.

131. It is questionable, however, if the supply of appliances of this kind to persons with permanent disabilities is a function of the Hospital Service. While the assistance of an occupational therapist is of great value in selecting suitable aids, there is little need for advice from hospital medical staff. It seems to the Committee, therefore, that except where aids are provided as an incidental part of a course of hospital rehabilitation, they should be provided as a welfare service by the local authority. A local service of this kind is analogous to the existing functions of welfare authorities in relation to the adaptation of a disabled person's home and furniture to fit in with his own particular needs. The Committee accordingly RECOMMENDS that local authorities should assist permanently disabled persons living at home by providing them with necessary personal aids.

132. Aids to industrial activities will usually have to be made to fit the individual worker and the machine at which he is working, and the construction and the use of the aids may require medical advice and supervision. Much thought has been given in recent years to the production of "work aids", both in the form of personal prostheses such as special attachments to artificial arms and in the form of the adaptation of machinery or working conditions. Attachments to artificial arms may be provided under the National Health Service from a range of approved types designed for general purposes. Where the "work aid" consists of the adaptation of machinery or the work bench, this will normally be a matter for the employer. A considerable number of aids of this kind has been developed and tried out in the government training centres, industrial rehabilitation units, Remploy and other sheltered workshops, including workshops for the blind, and by voluntary organisations engaged in the training and employment of the disabled as well as by several industrial concerns. If the "work aid" is a special aid to employment, such as a braille micrometer or shorthand machine for the blind, it may be provided by the Ministry of Labour.

133. The Committee is pleased to learn that the Ministry of Labour is proposing to bring together a number of representative examples of "work aids" in a publication dealing with the subject generally. It hopes that this publication will be made readily available to those concerned and that the Ministry of Labour will continue to develop suitable "work aids".

134. In addition to appliances and gadgets of various kinds there is much that can be done to make life more tolerable for severely crippled people by various forms of structural alterations.

135. Under Section 29 of the National Assistance Act, 1948, local authorities may make provision for structural adaptations in the home, such as ramps and hand-rails, widened doors, raised toilet seats, bath seats and showers, alterations in the layout of kitchen fittings, etc. This is an invaluable service which some local authorities are now providing and the Committee RECOMMENDS that it should be extended to all areas.

136. Although much use is now made of self-propelled wheel chairs and invalid tricycles, the Committee has been informed that more could be done to help the disabled to use ordinary public transport and to fend for themselves in factories and offices. People with stiff hips find it difficult to negotiate the steep step from the conductor's platform to the inside of a bus. A stiff leg makes it difficult to travel at rush hours as other passengers often trip over the extended leg. Some buses have standing space near the entrance and this provides a solution. There is possibly also some need for educating the operators and users of public transport in the ways in which the burden of the disabled can be lightened. The whole question of helping the disabled in the use of public transport needs further study and the Committee RECOMMENDS that this should be done.

137. A few industrial firms have considered how to adapt the layout of work to assist those of their staff who are disabled, to provide parking space for invalid tricycles and access in wheel chairs to workshop, canteen and toilet, and to enlarge and adapt at least one toilet for each sex so that it can be used by chair-bound and other disabled employees. Assistance of this kind not only enables the disabled employee to retain his job and to work in greater comfort, but assures him of his employer's interest in his welfare. The Committee hopes that all employers will do what they can to assist disabled members of their staff in ways such as these.

CHAPTER VI. VOCATIONAL TRAINING

138. Whilst in the conditions of today much of the work in industry and commerce demands little of the special technical skill which would come from vocational training, other than that given on the job itself, a disabled person's prospects of satisfactory resettlement through employment will be much improved if he has skill and experience to offer which are in good demand in the labour market. Vocational training in a skilled trade is a ready means of satisfying this need, and where training is likely to lead to the most satisfactory form of resettlement for the disabled person and he is fully capable of absorbing and making use of the instruction given, the Committee has no doubt that facilities for training should be made available and disabled persons encouraged to use them.

139. Facilities for training the disabled can be provided under two enactments. The first is the Disabled Persons (Employment) Act, 1944, under which facilities (restricted to disabled persons) may be provided for those " not being under the age of 16 years, who are in need of training in order to render them competent to undertake employment . . . of a kind suited to their age, experience and general qualifications ". The second is the Employment and Training Act, 1948, not restricted to disabled persons, under which the Minister may provide training courses " for the purpose of assisting persons to select, fit themselves for, obtain and retain employment suitable to their age and capacity ". Both these Acts are administered by the Ministry of Labour. For training in agriculture and horticulture, facilities are provided through the Ministry of Agriculture in England and Wales and the Department of Agriculture for Scotland. Before a disabled person is accepted for training, his medical condition, his capabilities and the prospects of employment after training are all taken fully into consideration. In most cases the training can be provided at one of the 16 Government training centres run by the Ministry of Labour. These are generally non-residential centres, but residential accommodation is attached to one centre and is available in a hostel a little distance from another ; at the remainder suitable lodgings are arranged for trainees who come from a distance.

140. For the more seriously disabled persons, likely to be suitable for employment in ordinary industry, but likely to find it too great a strain to travel to a Government training centre each day, training opportunities leading to employment are provided in four residential colleges run by voluntary organisations with the financial support and technical advice of the Ministry of Labour. In addition, special classes are conducted on the Ministry's behalf by technical and commercial colleges where the demand justifies it. If there is insufficient demand for the establishment of a special class, individual trainees can be admitted to existing classes in these establishments. Where suitable training for a disabled person cannot be effected in any of these ways—either because a class is not available for the selected occupation, or because personal circumstances require that the training should be undertaken in the home area—arrangements may be made for individual training to be given by specially selected employers, who are reimbursed their out-of-pocket expenses for this service by the Ministry of Labour. As is shown in Appendix E, which lists the occupations in which vocational training was provided for disabled persons in the first half of 1956, the actual range of training trades is very wide.

141. In some cases special arrangements have been made for training persons suffering from particular disabilities—e.g., engineering training for the blind; various experimental part-time training arrangements for the tuberculous; and the special classes for epileptics, also experimental, at Lingfield Colony.

142. Except in the four colleges run by voluntary organisations, the disabled are generally trained side by side with the able-bodied, although certain training classes within centres may be available only to the disabled. The curriculum is adjusted, if necessary, to meet the special needs of the disabled and the period of training (normally 6–9 months) may be extended for them. About 5,000 disabled persons were admitted to training courses in 1955 at Government training centres, technical colleges, residential colleges and in employers establishments, and it is estimated that during the last ten years about 50,000 disabled persons have been given the benefit of vocational training. The cost of training and maintenance of the trainees is borne by the Ministry of Labour.

143. The disabled can also be helped in taking professional courses of training or study if such courses are necessary for their satisfactory resettlement in employment suited to their age, experience and general qualifications. Applicants who qualify for these courses make their own arrangements for training and these have to conform to the requirements of the professional bodies concerned. Financial grants are payable for maintenance, tuition and examination fees and books, etc. The average number of applications for such assistance over each of the last five years was 185, of which 21 were subsequently withdrawn and 81 were granted.

144. Some of the evidence submitted to the Committee seemed to suggest that training should be made more readily available to disabled persons. The Committee thinks it important to point out that for all training courses the applicant must have the appropriate education and aptitude to enable him to absorb the required instruction under the intensive training conditions which apply. Furthermore, such factors as the suitability of the disabled person for training, the prospects of employment after training, and the distance from a training centre will always impose a limitation on the extent to which training can be given. The Committee thinks, however, that within the unavoidable limitations, the facilities provided are as wide as is reasonably

practicable to enable disabled persons who are in need of training for effective resettlement, and are capable of benefiting from it, to take a suitable course of training.

145. Suggestions were made that frequently training was not available locally, and that when available, the range of trades in the local training centre was limited. The Ministry of Labour states that the declining number of applicants coming forward has led to an inevitable reduction in the number of classes provided in Government training centres as a whole. The number of trades covered has not to any appreciable extent been reduced but it has not been possible to provide courses in all of these trades in every centre. The Committee believes that the range of occupations for which organised classes can be maintained is bound to be limited, but as such classes are desirable from many points of view it hopes that as many as possible should be kept open. The Committee is impressed by the flexibility of the present facilities which enable many different arrangements to be made for the provision of training.

146. As to the part played by vocational training in the resettlement of the disabled, it is understood that about 95 per cent. of all disabled persons who completed Ministry of Labour vocational training courses in 1955 were successfully placed in the occupations for which they had been trained. It would seem, therefore, that under present conditions at least, the skills acquired by trainees make them readily acceptable to industry. But not all those who take up courses of training complete them, and about 23 per cent. terminate their courses prematurely. About half do so because of sickness which could not be foreseen at the time of entry into training, or through the unexpected worsening of their disabilities. Many of this group ultimately resume training and complete it satisfactorily. Of the others, one of the largest single groups consists of those who find work before completing their course, usually at a very early stage in their training; and with the present demand for labour this is not surprising. Other reasons given by trainees who leave voluntarily are domestic and financial difficulties; taken together they account for about one half of the total losses. Of all disabled persons entering upon courses, under 4 per cent. are discharged because of their lack of ability to make good in training. The Committee does not think that this situation need cause undue concern, particularly as a fair proportion of the terminations are made during the early stages of training. Some waste of training resources through premature terminations may be regarded as inevitable, and the application of more severe standards at the selection stage might well exclude many disabled persons who stay the course to the end and are successfully placed.

147. Suggestions were made to the Committee that more training should be done by employers and less by training establishments in organised classes. In general, employers are co-operative and undertake " on the job " training of disabled persons in exactly the same way as they do for the able-bodied. This is particularly the case where the work to be done needs comparatively little skill or where the operations are particular to the employer concerned. For many of the more skilled occupations organised classes under the vocational training scheme are available, and these classes are planned to secure that an adult trainee is able to acquire in six to twelve months a level of skill which the ordinary entrant into industry would only obtain after three or more years. The Committee thinks that, wherever numbers make it practicable to set up special training classes, the skilled and experienced instructors who are employed in Government training centres and in other establishments are likely to provide the systematic and intensive training

more quickly and more effectively than could most employers. Furthermore, such special establishments, able to make adjustments in working conditions and in training schedules to suit individual disabled persons, provide a very useful pre-employment stage for the disabled. Where for various reasons skilled training cannot be carried out conveniently in training establishments, the Committee thinks that the Ministry of Labour is right to encourage employers to train the disabled, giving them, as now, financial assistance to meet some part of the cost of training.

148. There was some criticism of delay in providing training. Such criticism is almost bound to arise, but taking into account factors such as a common date of intake for certain courses and the assessment of a candidate's suitability there would appear to be very little, if any, avoidable delay in dealing with applications.

149. The adequacy of the allowances at present payable to trainees was the subject of some criticism, but the Committee sees no reason to suggest any change in the official policy of fixing such allowances at a point in excess of unemployment and sickness insurance benefit, but below the average wage that would be payable generally to trainees on first entering employment in their training trade. It is understood that the allowances are under continuous review by the Ministry of Labour and that they are revised not infrequently. The present rates of allowances containing revisions operating from 23rd January, 1956, are given in Appendix F.

CHAPTER VII. THE WIDENING OF EMPLOYMENT OPPORTUNITIES IN ORDINARY INDUSTRY

General

150. Earlier chapters have reviewed the considerations affecting a disabled person in his transition from the first stages of disablement to the point where, although he may continue to need medical care, he will wish to free himself from the protective atmosphere of the hospital and increasingly to seek his place in normal society. In the review of this transitional period the provision of welfare services to cope with social stresses of one kind or another, and the availability of measures designed to prepare the disabled person more adequately for employment have been noted.

151. The Disabled Persons (Employment) Act, 1944, to which reference has already been made, emphasised the importance of employment as an element in the resettlement of the disabled and, besides the provisions relating to industrial rehabilitation and vocational training already dealt with, it introduced other features—some of them novel—to make it more possible for disabled persons to take up employment of a kind suitable for them. Whilst the Act is primarily concerned with facilitating the employment of disabled persons in ordinary industry so that each might, as the Tomlinson Report said, take up employment "which he can take and keep on his merits as a worker in normal competition", it also makes provision for the "small group (of disabled) who cannot hold their own on level terms and under competitive conditions" and therefore need work under sheltered conditions.

152. This and the two following chapters are concerned with the remaining provisions of the Act. This chapter deals with voluntary registration of the disabled, the compulsory schemes for employment, and general questions relating to employment; Chapters VIII and IX deal respectively with the two means of providing sheltered employment—in workshops and in the home.

153. A disabled person unable to return to his former job after injury or illness or engaging in work for the first time, may naturally find it difficult to obtain employment of a kind suited to his disability. Disabled workers who from time to time lose employment and seek new work may find the same difficulty. The placing service of the Ministry of Labour, which is available to all workers, is also available in a special form for the disabled, but additionally for the disabled person there are statutory provisions designed to widen the range of employment opportunity. The following paragraphs deal with these provisions and the placing service for the disabled and also touch on two other factors affecting employment opportunities.

(1) The Disabled Persons Register

154. Under the Disabled Persons (Employment) Act a register of disabled persons is maintained at the local offices of the Ministry of Labour and National Service. Registration is voluntary but before any disabled person can be admitted to the register he has to prove, among other things, that he is substantially handicapped in getting or keeping suitable employment or work on his own account, that he has a reasonable prospect of getting and keeping such work, and that his disablement is likely to last for at least six months. There are arrangements whereby the disablement resettlement officer can obtain up to date medical evidence to enable these assessments to be made. Any cases of doubt are referred to a Disablement Advisory Committee for its recommendation. The period of registration varies according to individual circumstances, from a minimum of one year to a maximum of five years, and may be renewed on expiry. Disabled pensioners of the 1914–18 war are registered without question so long as they are in receipt of their pension. As mentioned in Chapter I, paragraph 17 above, the number of registered disabled persons at 16th April, 1956, was 798,279.

155. The particulars of unemployed registered disabled persons are recorded at local offices and for convenience are divided into two sections. Section I contains the particulars of disabled persons who are capable of employment under ordinary conditions and Section II contains the particulars of those who are so severely disabled that they are unlikely to obtain employment except under sheltered conditions. In Appendix G is given a statement of the extent of unemployment of registered disabled persons over the last three years.

156. Only registered disabled persons are eligible for inclusion in an employer's quota (see paragraph 166) and for designated or sheltered employments.

157. The question of registration as a disabled person under the Disabled Persons (Employment) Act was touched on by several of the organisations giving evidence to the Committee. In particular, two of the main conditions of registration, that of being "substantially handicapped in obtaining or keeping employment" and of having a "reasonable prospect of employment" were the object of comment. Although much of the evidence was contradictory, its main intention was to ensure that the regulations were amended or interpreted in such a way that only those disabled persons who needed and could benefit from the provisions of the Disabled Persons (Employment) Act were included on the register.

158. So far as the interpretation of the "substantially handicapped" condition was concerned, one criticism made was that persons with trifling disabilities which did not seriously interfere with their wage earning capacity were being admitted to the register and that perhaps, in consequence, the

present regulation needed strengthening. If the present regulation is properly interpreted, however, it should bring about this result, and the Committee understands that the Ministry of Labour has recently issued instructions on this matter.

159. It was also suggested that the present arrangements for proving disability under the "substantial handicap" regulation left too much to the responsibility of the individual disablement resettlement officer, and it was felt that admission to the register should be based on a degree of disability measured in terms of percentage as in the case of war pensioners and industrial injuries pensioners. Pensions are based, however, on loss of physical capacity and normal health and strength, while the criterion for disability under the Disabled Persons (Employment) Act is the effect of the disability on the person's employment capacity. It follows, therefore, that the same disability may be a substantial handicap in relation to one type of employment but may be no handicap at all in another, and that it would be impossible to assess "substantial handicap" with any exactness either in the individual case or in one case in relation to another. The Committee has accordingly reached the conclusion that a percentage standard of disability for registration purposes is quite impracticable.

160. The interpretation of the condition "reasonable prospect of employment", together with the allied problem of those persons who may be thought to be unemployable, was also the subject of comment. It was suggested that there should be a purge of the register so that any persons at present on the register who are regarded as unemployable should be removed and that in future any such persons should be excluded from registration. Other proposals were that these persons should remain on the register but should be dealt with in a separate section. The first difficulty in approaching this problem is to decide whether a disabled person is unemployable. All persons drawing unemployment benefit or national assistance at an employment exchange must be "capable of work", so that prima facie they should be able to undertake some kind of work, although the range of what is possible may be restricted. But among the unemployed disabled there are undoubtedly some who although capable of doing some kind of work are unlikely ever to get it, not because of the absence of employment but because, despite all steps which may have been taken to rehabilitate them, they are unresponsive to the call of work or employers refuse or are reluctant to engage them. The Committee does not think it practicable or desirable either to attempt to purge the existing register of unemployables or to set up a separate section of those who might fall within this category. So far as the satisfaction of the "reasonable prospect" condition is concerned, the Committee considers that the best time to decide on this question is at the time of renewal of registration, and that the disablement resettlement officer and Disablement Advisory Committee Panels should at this stage, when they have an applicant's employment record and other details in front of them, be very much stricter in the interpretation of this regulation. The Committee RECOMMENDS that as assessment of acceptability for work will often turn on medical evidence, specialist medical opinion should be available to reinforce or advise disablement resettlement officers and Disablement Advisory Committee Panels on the problem cases. The ideal way of doing this would be by using hospital resettlement clinics for some of this work, and this proposal is considered, and a recommendation made, in Chapter II.

161. Another condition for registration is that the disability need be expected to last only for a minimum period of six months. At the same time the minimum period of registration is one year. The Committee thinks

it questionable that a disability for so short a period as six months should establish a case for "substantial handicap", and having regard to the minimum period of registration it RECOMMENDS that the qualifying period should also be one year.

162. It was suggested that those disabled whose disabilities were unlikely to diminish as handicaps should be given registration for life instead of for the present maximum period of five years. Apart from advances in medical knowledge having the effect of reducing the handicap, the Committee does not consider that this is practicable, as there would be no longer any check on the currency of the registration and the names of persons no longer in the employment field would remain on it indefinitely. It is RECOMMENDED that a maximum period for registration should remain though it might be longer than the present period of five years.

163. It was also proposed that the registration regulations should be examined to ensure that patients of hospitals or similar institutions who are able to engage in employment are not disqualified from registering as disabled persons. The Committee considers that this is a reasonable proposal and RECOMMENDS that it should be accepted.

164. The special regulations dealing with the position of non-British subjects under the Act were drafted soon after the war and have a certain bias towards aliens with a war service qualification. The Committee thinks that these regulations are now outdated and RECOMMENDS therefore that, provided an alien satisfies the normal eligibility conditions, the benefits of registration should be extended to all those who are in the country on a work permit without reference to any residential qualification.

165. Although registration is voluntary the present regulations make no provision for the voluntary removal of a name from the register, and it sometimes happens that a registered disabled person no longer wishes to remain on the register. At present his name cannot be removed until the expiry of his period of registration. The Committee RECOMMENDS that the regulations be amended to make provision for the voluntary removal of a disabled person's name from the register on receipt of a written request from him.

(2) The Quota Scheme

166. Under the Act every employer with 20 or more workers is required to employ a quota, at present three per cent., of registered disabled persons, and must keep records to show the number of registered disabled persons he employs. An employer who is below quota may not, without a permit from the Ministry of Labour, engage an able-bodied worker, nor may an employer discharge a registered disabled person without reasonable cause if such a discharge would leave him below his quota. Special percentages can be fixed for industries specially suitable or unsuitable for the disabled, but so far only one has been fixed, namely a specially low percentage—0·1 per cent.—for ships' crews in the shipping and fishing industries. An employer may apply for a reduction of his quota but such applications are rarely made and so far none has been granted.

167. As a result of an annual enquiry and the information obtained from the inspection of employers' records it is estimated that some 66,000 employers are subject to the quota requirement and that they employ an average of 3·5 per cent. registered disabled persons. There have been comparatively few failures on the part of employers to keep to their obligations, although at first there were many minor, mainly technical, infringements. It

has been the practice to take proceedings in law only when infringement has been flagrant, and since the operation of the Act there have been only four prosecutions.

168. The Committee received no evidence suggesting that the quota should be abolished, although attention was drawn to the fact that in Scandinavian countries the quota scheme was not favoured on the ground that in times of full employment it was unnecessary, and in periods of depression unenforceable.

169. From the evidence received and heard, the Committee thinks that while the quota scheme has been, in some instances, of great assistance to the disablement resettlement officer in his normal placing work, its main value has been that it has provided a sound basis for publicity among both employers and workpeople to show the industrial value of disabled persons. As one of the witnesses put it, the quota scheme " builds up a sense of public responsibility towards the disabled ". Investigations have shown that the quota has become generally acceptable to industry, and although it may be largely unnecessary in a time of full employment the Committee believes the educational importance of the quota scheme to be such that it should continue.

170. Various suggestions were made for modifying the present quota arrangements. There was a certain amount of conflicting evidence as to whether the present quota of 3 per cent. should be raised or lowered; proposals were made for differential quotas on either an industrial or regional basis; and it was also suggested that in view of the relatively small number of disabled women there might be differing percentages for men and women.

171. The Committee has considered all this evidence most carefully but does not wish to recommend any amendments to the existing regulations relating to the scheme. The present standard percentage appears to be satisfactory, and apart from certain industries and localities where employers do not find it possible to satisfy the present quota and where a considerable number of permits to engage non-disabled persons have to be issued, the Committee is satisfied that most co-operative employers have little difficulty in meeting their quota obligations. The Committee also considers that adequate arrangements are provided for a revision of the standard percentage wherever necessary. Differential quotas on a predetermined basis are not favoured, partly because of the administrative difficulties which they would create, and also because of the anomalies and inconsistencies which they would be bound to introduce. If a firm or industry employing mainly women can make out a satisfactory case for a reduced quota, the Act provides the necessary machinery for bringing such a quota into force.

172. It was also proposed that the present definition of " employer " for quota purposes should be altered so that firms or organisations with several branches who are at present treated as one unit, should be able to have each branch treated separately. The Committee is not in favour of any change in the definition of " employer " for quota purposes, as it seems only fair that large firms operating small branch establishments should be subject to a quota covering all their staff; otherwise they might be exempted from the obligations altogether, as many of the branch establishments would employ less than 20 persons.

173. So far as the disabled persons themselves are concerned, some of the evidence propounded various methods of weighting the disabled for quota purposes according to the degree of disability, the object being to give employers additional recognition for the employment of the more seriously

handicapped. This, of course, is closely linked with the proposal to register disabled persons by percentage degrees of disability, a suggestion which is considered in paragraph 159. In discussions with employers on this subject it was pointed out that any scheme based on percentage of disability, however theoretically attractive, would give rise to serious practical difficulties; and the Committee has come to the conclusion that the weighting of disabilities for quota purposes is impracticable because of the difficulty of any precise measurement of disability in terms of employment handicap.

174. The most controversial issue in connection with the quota was the present rule under Section 13 (6) of the Disabled Persons (Employment) Act, which permits registered disabled persons whose registration has lapsed or has not been renewed to count towards their employer's quota for so long as they remain with the same employer. Some arguments were put forward in favour of the abolition of this provision but on the whole it seems preferable that it should remain. It is clear that the counting of lapsed registrations gives rise to only minor injustices as those disabled persons who do not trouble to renew their registrations would often be eligible for re-registration if they applied. Also, as has been said elsewhere, the disablement resettlement officer's effectiveness depends in the last resort on the goodwill of employers and if an employer is willing to engage a registered disabled person, it seems just that he should be allowed to count that person towards his quota for the whole of his period of employment. If this provision were abolished there is a risk, although perhaps a slight one, that a lapsed registrant would be discharged by the employer simply because he was no longer a registered disabled person. The Committee therefore considers that there should be no change in the provisions of the present Section 13 (6) of the Disabled Persons (Employment) Act.

(3) **Designated Employment Scheme**

175. As a supplement to the quota scheme the Minister of Labour has powers under the Act to require that vacancies in certain "designated" occupations shall be filled by registered disabled persons irrespective of the size of the employer's establishment, and that a permit shall be obtained by an employer who wishes to engage a non-registered person for these types of employment. So far two occupations, those of car park attendant and passenger electric lift attendant, have been designated. At the end of 1953 a special enquiry revealed that about 4,080 registered disabled persons were employed in these two occupations.

176. The Committee has not received very much evidence about the operation of the designated employment scheme and it would appear that designation of the two occupations, car park attendant and passenger electric lift attendant, is generally acceptable and helps to provide jobs for some of the less skilled disabled persons, especially those in older age groups. The Committee RECOMMENDS, therefore, that these two occupations should continue to be designated.

177. Some of the evidence has suggested that there should be an extension of the scheme, and other evidence tended to point to the difficulties of extension. Formal designation is liable to give rise to difficulties of definition. In practice, designation can be applied only to low-grade employment, and any extension of the scheme might encourage the mistaken and undesirable belief that disabled persons are only capable of that type of work. Good placing work by disablement resettlement officers depends upon the goodwill and co-operation of employers, and it is far better to rely on the skill of the disablement resettlement officer and the willingness of employers to

engage disabled persons in those occupations which are suitable for them than to extend the system of formal designation. The Committee has received evidence that many firms do in fact implement an informal system of designation by reserving certain jobs especially for disabled persons, and it thinks such informal designation should be encouraged as much as possible.

178. The quota scheme and the designated employment scheme have the same general objective but approach it by different routes. If at any time there should be need for more pressure on employers to employ disabled persons, the Committee RECOMMENDS this should be done through the quota scheme rather than by any extension of designated employments.

(4) The placing of the disabled in employment

179. In order to carry out the employment provisions of the Act, a special service for the disabled has been set up within the general employment service of the Ministry of Labour. At each of the local offices of the Ministry there is a disablement resettlement officer whose responsibility it is to assist disabled persons who are capable (or likely to become capable) of remunerative employment to find such employment. His responsibilities in respect of blind persons are restricted (see Chapter X, (*a*)). The majority of disabled persons are likely to be capable of work in ordinary industrial concerns and for only a small minority will work under sheltered conditions be necessary. Those disabled persons not capable of remunerative employment are not directly the responsibility of the disablement resettlement officer, although he will often advise such persons and put them in touch with other organisations or authorities who may be able to help them.

180. There are comprehensive arrangements under which the disablement resettlement officer can obtain a medical report designed to give him medical advice on the individual's capabilities and the conditions of employment likely to prove suitable. For medical guidance on problem cases, Medical Interviewing Committees consisting of a hospital doctor and an industrial doctor with a disablement resettlement officer in attendance have been set up at some of the larger hospitals. Taking into account this medical information, the applicant's experience and qualifications, a knowledge of the requirements of local employers obtained first-hand and as expressed in vacancies notified by them to the local offices of the Ministry, the disablement resettlement officer endeavours to place the disabled person in suitable employment. Where suitable employment is not forthcoming in this way he approaches employers to ascertain if any suitable jobs are available for individuals who may be found difficult to place. He follows up all his first placings after disablement or after training to make sure that the resettlement has been satisfactory, and all disabled persons entering employment are invited to consult him if they find difficulty in undertaking the work.

181. Disablement resettlement officers, who may devote all or part of their time to this work according to the volume of work, are part of the staff of the employment exchanges. If they are full-time they will work in close association with other staff engaged in employment work; if they are part-time they will usually be engaged also in the placing of non-disabled persons. They are selected from amongst officers who have been trained in the employment service for some years. On taking up the specialised work of the disablement resettlement officer they are given a short basic course followed by two specialised courses at residential centres. On 30th June, 1956, there were 1,545 disablement resettlement officers of whom 178 men and 6 women were full-time and 873 men and 488 women were part-time on the work. In addition there were 65 full-time group disablement

resettlement officers responsible for advising and assisting part-time disablement resettlement officers over a given area and normally carrying out hospital interviewing in that area. Whilst disablement resettlement officers will from time to time move on to other work (including disablement work at regional offices and headquarters) it is normal practice to retain full-time disablement resettlement officers on their duties for at least five years if they are carrying them out satisfactorily and to keep part-time disablement resettlement officers on the work as long as possible, taking into account the needs of the employment service as a whole.

182. The Committee received a great deal of evidence concerning the placing of disabled persons in employment and has therefore given this question close consideration. The Ministry of Labour's policy as regards placing disabled persons in employment is based on the report of the Tomlinson Committee, which took the view that the only completely satisfactory form of resettlement for a disabled person is employment which he can take and keep on his merits as a worker in normal competition with his fellows. The present Committee is sure that this is sound policy, and most of the evidence received supported this view. The Ministry's experience over the years has confirmed this view and has shown that, with careful assessment of individual capacity and correspondingly careful selection of employment, most disabled persons are capable, or can be rendered capable by training and rehabilitation, of taking their place in industry or other employment. Only for the minority of disabled persons who because of the severity of their disability are unable to enter ordinary employment, is the provision of sheltered employment necessary. This is a subject dealt with in Chapter VIII.

183. Much of the evidence received, especially that from professional associations of workers in the rehabilitation field, concerned the status of the disablement resettlement officer and the nature of his functions. The Committee accepts the view of the Ministry of Labour that the role of the disablement resettlement officer is primarily that of an employment officer, as his main concern is with the placing of disabled persons in suitable employment, either directly or following industrial rehabilitation or training, and while he must appreciate the special needs of the disabled, he should not be regarded as a social worker in the specialised sense of the term. The basic principles of ordinary placing work and disablement placing work are exactly the same, though because he is dealing with disabled persons the disablement resettlement officer has certain special demands made on his time, and he needs to exercise considerable tact, show understanding and human sympathy, as well as to have a good deal of knowledge of the implications of disabilities on working capacity.

184. From several sources there came a suggestion that the disablement resettlement officers should be recruited from the ranks of trained social workers. It was argued that in present times of full employment the difficult problem cases would be better dealt with by a social worker who might more easily understand the medical view point, the nature of the disability and, as a result of his training, be aware of the special difficulties of handling the problems of the severely disabled. It was admitted that trained social workers would not have the industrial knowledge of the ordinary disablement resettlement officer, but it was suggested that they could easily acquire this.

185. The Committee believes that these views arise mainly from a misconception of the role of the disablement resettlement officer, possibly brought about because in the absence of supporting social services he has frequently had to undertake work which is more appropriate to the trained

social worker. There is also, perhaps, a tendency to underrate the skill which it is necessary for an employment officer to acquire in the industrial field.

186. Having carefully considered the arguments in favour of recruiting disablement resettlement officers from the ranks of trained social workers, the Committee is not convinced by them. It accepts the view that the present basis of appointment of disablement resettlement officers is right, but at the same time it recognises that there is a social element in much of the work done by the disablement resettlement officer in which he would be well advised to seek the advice and assistance of medical and social workers wherever necessary. It is important that he should be able to recognise the type of case needing such services and know where these may be obtained.

187. As a corollary of the above suggestion, it was also proposed that the disablement resettlement officers should form a specialised service within the Ministry of Labour and that officers in it, whether recruited from the Ministry's normal staff or specially recruited from outside, should remain in this service for the whole of their official career and not, as now, be interchangeable with other officers of the same grade on other sections of the work. Such a conception of a specialised service for placing the disabled in employment would not be in keeping with the accepted position that the disablement resettlement work is part of the Ministry's normal placing work and that the general run of job vacancies will be notified by employers to the placing section and not to the disablement resettlement officer. The Committee believes there are also advantages in having a service which enables changes in personnel to be made from time to time to maintain and improve the service, provided the turnover of staff is not unreasonable.

188. The present turnover among disablement resettlement officers has been examined and the Committee has been assured that it is the aim to retain an officer on disablement work for at least five years and that changes are avoided as far as possible. It was found that in some instances changes had been necessary on account of illness, retirement, promotion or unsuitability of a particular officer for disablement work. In all the circumstances the Committee is satisfied that the present organisation is the most suitable for the purpose.

189. The Committee is not entirely satisfied with the present methods of recruitment and selection of staff, however, and RECOMMENDS that the Ministry of Labour take steps to secure that its methods of selection are such as to ensure that in the case of all disablement resettlement officer appointments the fullest consideration is given to the question of the officer's suitability and inclination for this work.

190. The Committee has given careful thought to the training which the Ministry of Labour provides for its disablement resettlement officers, which is aimed at ensuring that they can take their place and co-operate with other qualified members of the rehabilitation team. Though it is thought that the medical courses and the Roffey Park courses are adequate, and that they should be retained in their present form, the Committee is not altogether satisfied with the adequacy of the initial training given to disablement resettlement officers on their appointment. It is RECOMMENDED that the present three to four-day course should be very considerably extended in time so as to make it far more comprehensive, and that it should include such a period of training on the job, under the supervision of a group disablement resettlement officer or experienced local disablement resettlement officer, as will thoroughly equip the newly-appointed officer for the work he is to do.

191. So far as the organisation of the disablement resettlement service is concerned, it is thought that the present emphasis on a local service is right, and that in smaller offices service should be provided by part-time disablement resettlement officers assisted and advised by group disablement resettlement officers. The Committee considered whether there should be a system of specialised disablement resettlement officers for particular disabilities but decided that, generally speaking, any system of disablement resettlement officers specialising in one disability would be undesirable because of the inevitable increase in the number of placing officers having direct contact with employers; the reduction in local effectiveness due to the widening of the area of activity of such specialists; and the risk that concentration on a few selected disabilities would be prejudicial to the interests of other disabled persons. The Committee RECOMMENDS that disablement resettlement officers should deal with all disabled persons within a specified area, whatever their disabilities and that they should continue to co-operate with voluntary organisations, hospitals, local authorities and doctors in that area.

192. Part-time regional medical advisers, five in number, have been appointed at various dates since 1946 to advise the Ministry of Labour at regional level on medical questions relating to the training and employment of the disabled. The character of the work done has varied according to the nature and incidence of industry in the area covered and the importance of injuries and diseases most prevalent, but one aim throughout has been that the regional medical adviser should act as a link between hospitals, doctors and those concerned with employment opportunities so as to impart to both doctors and laymen a broader knowledge and understanding of the parts which each play in services for the disabled. Success in the work to be done has depended partly on the acceptance among the medical profession of those appointed and partly on the essentially personal contribution which they have been able to make. The Committee hopes that its proposals in Chapter II for the setting up of rehabilitation committees of regional hospital boards and boards of governors will in time obviate the need for ad hoc liaison appointments of this kind, but in the meantime it considers that where useful work can still be done by the medical advisers referred to their appointments should be continued

(5) **Other factors affecting employment opportunities**

(a) *The effect of superannuation schemes*

193. A number of organisations and individuals suggested that the operation of superannuation schemes adversely affected the employment of the disabled. The Committee has considered the evidence it has received on this subject and can see no reason why the operation of superannuation schemes need prejudice the employment of the disabled.

194. Civil Service superannuation schemes provide for the employment of the disabled, and the Committee understands that local authorities operate their superannuation schemes so that there is no deterrent to the employment of the disabled. The Committee is satisfied that for these two types of employment there is no reason to suppose that superannuation conditions have any influence on the appointment of a disabled person. It is also understood that nationalised industries adopt a sympathetic attitude towards the employment of such persons.

195. The Committee has been informed that in private firms it should always be possible to make provision for the disabled in superannuation schemes, though it does sometimes happen that disabled persons are precluded from employment because of such schemes. In all such instances

the Committee suggests that employers should seek the advice of the Association of Superannuation and Pension Funds or of the Life Office concerned on the various ways in which modifications may be introduced in order to provide greater flexibility. A description of the different types of scheme which are common in private firms and their effect on employment will be found in Appendix H.

(b) *Subsidies to employers for the employment of the disabled*

196. The Committee received some evidence suggesting that to facilitate the employment of severely disabled persons, employers should receive assistance in the form of a supplement to wages or of training grants in respect of those disabled who might not otherwise get employment. On the other hand both the Trades Union Congress General Council and the British Employers Confederation in their evidence to the Committee were opposed to any form of wages subsidy and were only prepared to consider the award of grants for adaptations or training in exceptional circumstances.

197. In the Committee's view a subsidy might mean that a disability, instead of being regarded as a handicap to be overcome in the right job, would tend to be looked upon as qualifying for a special financial consideration. It would act as a constant suggestion to the disabled that they were less capable than their fellow workers, who might in turn regard the disabled as a form of cheap labour. Several very real administrative difficulties also render the suggestion impracticable: in the difficulty of assessment of work handicap; in determining the amount of subsidy to be given; in the need of review of payments to meet changing conditions of health or employment; and in resisting extension of payment to employers who have so far willingly carried any extra costs involved. Whilst a form of subsidy might encourage a few employers to engage the disabled it might well lead to the discharge of some disabled persons who for one reason or the other would not qualify for inclusion, and it is doubtful where the balance would lie. The Tomlinson Committee in its report described subsidies to employers in these circumstances as undesirable in principle and impracticable. This Committee is in full agreement with the Tomlinson Committee's views.

CHAPTER VIII. REMUNERATIVE EMPLOYMENT UNDER SPECIAL (SHELTERED) CONDITIONS

198. Facilities under Section 15 of the Disabled Persons (Employment) Act, 1944, for training and employment under special (sheltered) conditions may be provided for registered disabled persons who by reason of the nature or severity of their disablement are unlikely, either at any time or until after a prolonged period otherwise to obtain employment. Sheltered employment may be provided by (*a*) local authorities having the necessary powers, (*b*) approved voluntary organisations, and (*c*) a non-profit making company set up by the Minister of Labour. Payments may be made by the Minister of Labour to these bodies in respect of the expenses incurred.

199. In its report the Tomlinson Committee said that "A large proportion of disabled persons is capable or can be rendered capable of taking their places in industry on normal terms" and further that "The use of institutional or sheltered employment must be limited to that small group who cannot hold their own on level terms and under competitive conditions". This Committee has no reason to dissent from these statements, and would only add that even if sheltered employment is found to be the only means of

providing disabled persons with a livelihood at any point of time, it should always be in the mind of those responsible that sheltered employment is only second best to competitive employment. It would follow, therefore, that as many as possible of those engaged in sheltered employment should be enabled as soon as possible to transfer to work under ordinary conditions. Nothing, in the Committee's opinion, could be worse than the prospect of a group of disabled people, some of them young on entering a workshop, remaining the whole of their working lives in a sheltered environment as a matter of course, and incidentally perhaps causing others with far better claims to sheltered work, to be excluded.

200. If sheltered employment in such terms is to be the success the Committee hopes it may be, it is important that there should be no misconception about the class of disabled who should benefit from it. Reference has already been made to those who no longer need the protective atmosphere of a sheltered workshop; it is equally important that the beneficiaries should be those who are willing to undertake the work provided and able to make a significant contribution to production. The significance of this can best be illustrated in sheltered workshops for the blind where the value of the work done can most easily be measured against the value of the remuneration received. Here the Committee notes that as an introduction to sheltered employment for the blind training is given which may last from eighteen months to as long as four years, but, nevertheless, the earnings of some blind persons in subsequent employment form only a small proportion of the actual wages received, the balance being made up of a supplementary payment known as augmentation to enable the total wage received to reach the level of certain scales operating for local authority unskilled employment. The Committee can well believe that payment of a flat minimum wage, irrespective of the value of production, has resulted in the relative value of work done in some workshops for the blind diminishing year after year. This may be partly due to certain of the workers being incapable of making a significant contribution to production, and the Committee is glad to note that there is some possibility of an arrangement being reached by which blind persons entering sheltered workshops will have to be able to demonstrate that they are capable of earning certain minimum rates before being engaged as workers. None the less the Committee does not regard the present system of augmentation as entirely satisfactory and would prefer to have a payment system which depended to some extent on incentive payments and had more regard to the value of the work done as indeed is the case in a number of workshops. The Committee hopes that those concerned will give further consideration to the introduction of such a system in workshops for the blind. In making these comments, the Committee would not wish to denigrate the valuable work done by the workshops and it notes with satisfaction that the annual value of goods produced by workshops for the blind is just over £2,000,000.

201. The Committee believes that all sheltered workshops, whether for the blind or the sighted, should be regarded as places of employment with as high as possible a rate of individual productivity. This does not mean that in the Committee's view, even with all the advantages of sheltered conditions, a severely disabled person must be fully capable of producing as much as a normal worker, but it does mean that if provision is to be made to occupy those who are capable only of a modicum of effort and industry, it should be provided for under the welfare provisions of the National Assistance Act and not through the employment service. In this connection, and in relation to workshops run by or on behalf of local authorities, the Committee is conscious that the National Assistance Act in its references to employment for

the "substantially and permanently handicapped" makes no distinction between those who are properly to be regarded as in the employment field and those who are not. It seems possible that this has resulted in some confusion, particularly as employment is included under the general heading of "Welfare Services". The Committee thinks it is important to draw a clear distinction between disabled persons in the employment field and those who are not, and having in mind the employment functions of the Ministry of Labour it RECOMMENDS that local authority powers to provide sheltered employment—whether in workshops or in the home, and whether for the blind or for the sighted disabled—should be transferred from the National Assistance Act to the Disabled Persons (Employment) Act in so far as they relate to persons who can be regarded as being covered by Section 15 of that Act and are therefore able to engage in remunerative employment. It should not be necessary for a local authority which has already obtained approval from the Ministry of Health of a welfare scheme which includes the provision of employment to secure further approval from the Ministry of Labour, but no doubt any new proposals in respect of sheltered employment would need to be sent to the Ministry of Labour instead of to the Ministry of Health. For those disabled persons whose work can be only of a diversionary character the welfare provisions of the National Assistance Act would continue to apply, and the Committee hopes that the proposals which it makes elsewhere for grants from exchequer funds to local authorities will encourage them to extend the provisions of this form of welfare.

202. Further discussion in this chapter on sheltered employment will relate only to that intended to provide a livelihood to those engaged in it.

203. The three methods of providing this: by (*a*) local authorities (directly or through voluntary organisations); (*b*) directly by voluntary organisations; and (*c*) a non-profit making company, are dealt with below:—

(1) **Local Authorities**

204. Under the National Assistance Act local authorities have the duty of promoting the welfare of blind persons including where necessary the provision of special workshops and under the Disabled Persons (Employment) Act the Minister of Labour may assist this provision by paying fees in respect of training (together with the payment of maintenance allowances to trainees) and grants towards meeting trading losses, together with grants towards approved capital expenditure incurred in respect of both training and employment. At 30th June, 1956, 293 blind persons were being trained and 3,837 employed in 69 Workshops for the Blind, 23 of which were managed directly by local authorities and 46 by voluntary organisations. During the year ended 31st March, 1955, local authorities expended approximately £1,000,000 on the provision of employment for blind persons in workshops for the blind and towards this expenditure grants totalling approximately £367,000 were payable by the Ministry of Labour.

205. Having regard to the association which local authorities have had over many years with workshops for the blind, the extent to which those workshops are managed directly by local authorities, and the close links which have been forged between them and the blind community, the Committee RECOMMENDS that the provision of work under sheltered conditions for the blind should continue to be a duty on local authorities but under powers given to them in the Disabled Persons (Employment) Act.

206. Local authorities have also a permissive power to provide workshops for other classes of severely disabled persons either in separate workshops or with the blind and financial assistance can be given by the Ministry of Labour

on the same lines as for the blind. No workshops have yet been provided by local authorities although plans for one have been approved, but a small number of disabled is employed or being trained in workshops for the blind, and financial assistance is being given by three local authorities to workshops run by voluntary organisations under approved arrangements.

207. As part of the after-care provisions for tuberculous persons under the National Health Service Act, 1946, local authorities may provide employment facilities for ex-patients needing sheltered employment. Two local authorities have village settlements; two other authorities have workshops, one of which is residential, the other non-residential. There are 69 persons being trained at these four centres. The village settlements are prepared to admit tuberculous persons from the areas of other local authorities provided that the authorities contribute towards the cost of providing employment. A proportionate grant from the Ministry of Health can be claimed in regard to this expenditure. The cost of training is met by the Ministry of Labour under the Disabled Persons (Employment) Act, 1944. Alternatively, local authorities may provide employment facilities for the tuberculous under the permissive powers conferred by the National Assistance Act, in which case the necessary financial assistance may be claimed from the Ministry of Labour under the Disabled Persons (Employment) Act. No local authorities at present exercise these powers for tuberculous persons under the National Assistance Act. The Committee believes that the responsibility for the employment of all types of disabled persons should be with the Ministry of Labour, and in paragraph 201 above it has recommended that local authority powers to provide sheltered employment should be transferred from the National Assistance Act to the Disabled Persons (Employment) Act. For the same reasons it RECOMMENDS that the provision by local authorities of sheltered employment for the tuberculous should be under the powers to be given under the Disabled Persons (Employment) Act.

(2) Voluntary Organisations

208. There are at present 30 approved voluntary undertakings comprising 38 workshops for the training and employment of some 766 severely disabled sighted persons under special conditions (these figures include the workshops for the sighted mentioned in paragraph 206). Many of them have the advantage of being residential. The Ministry of Labour gives financial assistance to these approved undertakings to cover the cost of training, grants of up to 75 per cent. of approved capital expenditure incurred, and in respect of employment an annual deficiency grant of up to £100 per head in respect of trading deficits incurred. During 1954–55 the amount of financial assistance involved was about £94,000. Much of the cost of providing work of this kind is borne by voluntary effort and although, in the Committee's view, it is proper that the responsible voluntary organisations should themselves provide a substantial part of the finance required, the Committee understands that some of the voluntary organisations are finding the greatest difficulty in continuing to meet expenses. Although it would be difficult to generalise, the Committee understands that, with few exceptions, a considerable trading deficiency is incurred, and that expressed in terms of cost per head of worker, this may be anything up to £300 or £400 per head per annum. The Committee commends the valuable work done by these voluntary organisations and considers that the Ministry of Labour should continue to assist them provided that the persons they employ satisfy the conditions laid down in paragraph 200 above, and that the workshops are efficiently managed and are open to inspection by the Ministry of Labour.

(3) Non-Profit Making Company (Remploy Ltd.)

209. When the Disabled Persons (Employment) Act became law in 1944 there was little existing provision for sheltered employment for the disabled, except for the blind, for whom both voluntary organisations and local authorities operated workshops. There were known to be large numbers of sighted disabled persons able only to undertake such employment and as local authorities then had no general powers to provide sheltered employment and as voluntary organisations (mostly local in character) could not be expected to do so, that part of Section 15 of the Act which empowered the Minister of Labour to set up a company to provide sheltered employment facilities was almost at once acted upon, with the establishment in 1945 of the Disabled Persons Employment Corporation Ltd. (later Remploy Ltd.). Its object is to provide remunerative employment under special conditions (including training for such employment) for registered disabled persons who are severely disabled in the terms described at the beginning of this chapter. The employment provided by the company is on productive work of a kind likely to be suitable for severely disabled persons, and its aim is to be as self supporting as possible. Its goods are produced for sale in the ordinary commercial market and to meet the orders of government or other public authorities. Government loans are made to the company to cover capital expenditure, and any loss on operation is also met from public funds. Its board of directors is appointed by the Minister of Labour and includes a number of prominent business men, trade union officials and persons with particular interest and experience in the resettlement of the disabled, besides full-time or part-time directors working on an executive basis. Seven or eight years ago there were more than 12,000 severely disabled persons unemployed and it was contemplated that as many as 136 factories might be provided; in fact it was decided in 1949 that the building programme should not then be extended beyond the provision of 90 factories. By 1952 all these factories had been built and were in use; since then no additional factories have been provided. The factories employ at present about 6,000 severely disabled workers, including about 130 workers who produce goods in their own homes. The company is engaged in various forms of manufacture such as woodworking and furniture, cardboard boxes, orthopaedic and leather goods, protective clothing, knitwear, light engineering, packaging, bookbinding and printing. Its annual sales in 1955–56 were about £3 million compared with £2,850,000 in 1954–55. Remploy estimates that in 1955–56 the deficit on trading was £2,466,000. This compares with the figure of £2,699,000 shown in the published accounts for 1954–55. In terms of cost per head of disabled workers employed this would be £402 per annum; this compares with a figure of £410 per annum for 1954–55 and £398 for 1953–54.

210. In its evidence Remploy Ltd. stated that the men and women employed "must be capable of productive work and they must be willing to work to the best of their ability. They are supervised by skilled technicians and a medical officer is appointed to each factory. They are paid a weekly wage at an hourly rate which has been arrived at as a result of discussions with appropriate trade unions; daily travelling expenses in excess of 6d. a day are met by the company. They qualify for a paid annual holiday, and a canteen and welfare service is provided".

211. Some of the evidence presented to the Committee was critical of the operation of the Remploy scheme; on the one hand it was suggested that Remploy sometimes engaged workers who were not in need of sheltered conditions, and on the other hand, that some of the workers engaged were unable or unwilling to make any significant contribution to production and would

therefore be better treated as outside the range of Remploy. The Committee thinks it inevitable that such criticisms should be made because the assessment of recruits for Remploy will not always reveal the potential value of the worker, which can be determined only by experience in the factory, and because the nature and severity of the disability will be only two of many factors determining suitability for sheltered employment. The disabled person's own attitude to work, and the nature and complexity of the work to be done, are other important factors to be taken into account. Nevertheless there may be better methods than those used for ensuring that the right types of severely disabled workers are recruited, and that they are given ample opportunities to exercise their full ability. Accordingly, the Committee suggests that Remploy should review its practice to see whether better standards of assessment of aptitude and capacity can be applied both before and during employment. The Committee is pleased to note the proposal to use industrial rehabilitation units experimentally to obtain an assessment of suitability of candidates for Remploy employment and to provide potential workers with toning up prior to such employment. The Committee recognises that because of their disability or for other reasons some workers will not make a significant contribution to output and may in fact impede others who wish to do so. It is important therefore that preliminary assessment should be able to indicate the degree of working capacity.

212. The Committee was told that the average age of disabled workers in Remploy factories is on the high side (about 44 per cent. of Remploy male workers are 50 years of age and over), and that absence due to sickness is very high, particularly in the winter months. (During the winter of 1955–56, the peak in some Remploy factories was 50 per cent. of the productive strength and 30–35 per cent. was not unusual. In addition to sickness, absence from work was caused by the state of the roads which at times made movement by wheel chair or by amputees almost impossible.) There is also a large labour turnover involving 700–800 workers leaving each year, including 250 who go into ordinary industry. These factors have acted as a brake on efficient production. Other considerations such as the small number employed in each factory involving disproportionately high overhead costs, and the scattered nature of factories, involving heavy warehousing and transport charges, have added substantially to the difficulties, financial and otherwise, in running the factories.

213. These difficulties were particularly burdensome in the early years of the operation of Remploy, but as a result of the strengthening of management and direction Remploy may be expected to consolidate its position in the future. Recently the company's organisation was thoroughly examined by the Organisation and Methods Division of the Treasury and the Committee understands that Remploy has accepted in great measure the recommendations of the Treasury Organisation and Methods Report. As the Committee sees it, Remploy is operating a social service for the disabled, but one which seeks to demonstrate that, given suitable conditions of work, even the badly disabled person may find a place again in industry and feel that he is making some effective contribution to the country's production. It is unreasonable, having regard to the difficulties enumerated above, to expect this social service to operate without a loss, particularly during an inflationary period when rising costs fall more heavily on a trading concern of this kind. Whilst the loss at present is undeniably heavy, and may well continue to be so, the Committee would deplore any attempt to assess the value of Remploy solely or even mainly in financial terms; although the extent of the loss cannot be ignored, the Committee does not think that the present figure

is in all the circumstances excessive. The Committee has no doubt that many severely disabled men and women have benefited greatly from the opportunity to work which Remploy factories have given them, often either for the first time in their lives or after long spells of illness and unemployment. These benefits, which are to the disabled and their families psychologically as well as materially advantageous, have also led to improved health and added skills, and the Committee is particularly glad to note that in each year some 250 Remploy workers leave the factories to take up work in outside industry. Although this operates to the disadvantage of Remploy—often by depriving them of their most efficient workers—the Committee hopes that everything possible will be done to encourage this movement not only because of the advantage it gives to those taking up work in ordinary industry, but also because by this free movement further opportunities will be given to those who await employment by Remploy and in the absence of it may remain unemployed and dispirited.

214. The Committee has considered how far there is a continuing need for Remploy factories to operate, having regard to the diminished number of severely disabled workers eligible for consideration for sheltered employment but remaining unemployed. It is noted that at present there are fewer than 4,000 such persons; that many of them are living out of range of Remploy factories; that some would be unsuitable for work which Remploy has available; and that in the present favourable circumstances some persons thought to be outside the ordinary employment field are none the less acceptable to employers. On the other hand, there are at least 6,000 persons for whom employment in a Remploy factory appears to be the only likely opportunity of employment; this number can reasonably be expected to be a minimum since, should economic conditions deteriorate, it would increase; also, as an important by-product of employment with Remploy, substantial numbers of disabled persons are sufficiently rehabilitated to be able to enter ordinary employment. On these assumptions it seems to the Committee that sheltered employment on this scale must continue to be provided. If this is so, then subject to what is said above, the right way of providing sheltered employment is through a non-profit making company such as Remploy Ltd.

215. Having these considerations in mind, the Committee RECOMMENDS that the present scheme of providing sheltered employment through Remploy factories should be continued.

(4) Work for sheltered workshops

216. In its report (paragraph 91) the Tomlinson Committee expressed the view that sheltered employment should be "provided as far as possible through the production of articles which are in regular demand for Government or other public purposes and which lend themselves to small-scale manufacturing processes". At present the Committee understands that about 30 per cent. of the sales of Remploy Ltd. derives from Government contracts, with some comparatively small additions from local authorities and nationalised undertakings; workshops for the blind get rather more than 8 per cent. of their work from central Government departments and 15 per cent. from local authorities; some voluntary organisations get a considerable proportion of their work from Government departments, others —particularly the small workshops—very little. Altogether, the value of Government contracts for all sheltered workshops in 1954–55 was about £2,300,000.

217. The Committee's attention has been drawn to a circular (T.C. 8/50) issued by H.M. Treasury in October, 1950, to all government departments in which those who are concerned with the purchase of goods from industry (" purchasing departments ") are asked to allocate a " fair share of suitable orders " to non-profit undertakings, i.e., sheltered workshops for the disabled and H.M. Prisons (known collectively as " priority suppliers "). No preference in price is given under these arrangements to priority suppliers but contracts may be offered them without recourse to competitive tendering on the basis of a " fair price " or, when competitive tenders have been invited, on the basis of the lowest tender price, subject always to the condition that purchasing departments may find it essential to give contracts to the outside trade, e.g., in order to maintain a necessary " potential " source of supply. It is understood that in practice this scheme has worked satisfactorily but for various reasons has not produced the volume of orders which might have been expected. In part this is because priority suppliers have frequently found it impossible, even after making allowance for the subvention from public funds, to compete with outside industry having considerably better resources in material and equipment. This is particularly the case in trades commonly employing female and juvenile labour at lower rates of pay than is normally payable to adult males in sheltered workshops. On the other hand, not all priority suppliers were able in earlier days to adapt themselves easily to the precise requirements of quality and delivery dates needed by purchasing departments. Whilst it is gathered that this fault has been largely remedied it may have led to some limitation in the number of orders offered.

218. The Committee is in no position to say to what extent there could be an increase in the value of Government orders given to priority suppliers, but the range of goods now made in sheltered workshops is fairly wide and it may be that orders to the annual value of £2,300,000 are on the low side.

219. The Committee has been interested to read of the system adopted in South Africa where 14 sheltered workshops employing some 1,760 disabled persons are operated by voluntary organisations but financed entirely from public funds. In 1950 it was decided that all factories should turn over to the manufacture, on mass production lines, of office furniture for government departments, who were directed to make their needs known to a central board in the Department of Labour before going to public tender. All orders are channelled through the department and distributed to the factories as they need work, the price being arrived at by the Department of Labour having regard to the costs of factory production. As a result the value of Government contracts rose from £183,807 to £574,768 in the year ending 31st March, 1954.

220. Whilst the Committee hesitates to recommend a similar compulsory scheme in this country, it urges that something should be done to increase the volume of orders to priority suppliers without additional expense to the purchasing departments. In particular, it would like the departments concerned to review the possibility of extending the practice of costing their contracts, so as to be able to offer sheltered workshops a large number of contracts on this basis for those goods which they can make satisfactorily. The Committee asks those concerned to consider again whether, with the more settled conditions now applying in sheltered workshops, it is necessary to maintain more than a nominal " potential " source of supply from outside industry, even if this leads to some limitation in this form of trading. In this connection it cannot do better than endorse what is said in the Tomlinson Report: " The full development of production [in sheltered workshops] will cause a corresponding reduction in the demand made upon competitive

industry for the articles in question, but this will have to be recognised as an essential feature of any national scheme to secure satisfactory employment for disabled persons who cannot find a place in ordinary industry".

221. In the Committee's view, the importance of a full and steady flow of work for sheltered workshops cannot be over-emphasised; and this is as much in the interests of those employed as in those who manage the undertakings and naturally wish to draw as little as possible on public funds for the purpose. Contracts from public sources are advantageous in that considerable savings are made in the cost of sales promotion and in the warehousing of stock for speculative buyers, and the Committee urges that both Government departments and local authorities should give sheltered workshops the fullest possible opportunity to tender for contracts in the wide range of goods which workshops can now supply.

222. At the same time it is doubtful if more than a part of their trade could be expected to come from public contracts, and the Committee believes that priority suppliers should continue to compete in the ordinary commercial market so that the opportunities for taking on work may be as wide as possible.

CHAPTER IX. HOMEWORKING SCHEMES

223. Under the powers mentioned in para. 102 local authorities can provide a service for those who, because of the severity of their disability, or otherwise, must be regarded as outside the scope of wage earning employment, but who, nevertheless, can occupy themselves usefully in work at home. They can also provide sheltered employment (see Chapter VIII) or remunerative home employment, referred to in paras. 229–234 below.

224. The term "homeworker" is related to a wide variety of occupations and employment. As the Committee is concerned solely with the disabled, the traditional homeworking trades (e.g., glove making) which in certain areas are organised on an outwork basis, are not under discussion. The existence of these industries has no direct bearing on this chapter. For administrative purposes disabled homeworkers may be divided into two categories: those capable only of diversionary occupations or handicrafts primarily intended to be of therapeutic or morale-building value ("occupational home-work") and those capable of earning their living with or without supplementation from other sources ("remunerative home employment").

(1) Occupational home-work

225. Some local authorities run, either directly or through voluntary organisations, homeworking schemes of a diversionary character which include the teaching of handicrafts to home-bound disabled persons. The handicrafts are taught by handicraft instructors or (less frequently) by occupational therapists. No grant from central funds is made in respect of these schemes.

226. For the war-disabled the welfare arrangements made by the Ministry of Pensions and National Insurance include a homecrafts service which is run with the help of local War Pensions Committees, and voluntary organisations and funds catering for the ex-service community. This service provides upwards of 6,000 severely disabled pensioners, many of whom are "home-bound", with a wide variety of creative activities in their homes mainly in the form of arts, crafts and hobbies. The service is primarily recreational in purpose but pensioners are assisted in disposing of surplus products

by sales which are organised locally at frequent intervals. Wherever possible, these pensioners are encouraged to attend homecrafts clubs or centres, where training and work are combined with social activities.

227. Disabled persons who are engaged in the production of handicrafts or in other diversionary or therapeutic occupations, can (if otherwise eligible) draw National Insurance benefits and pensions subject to certain earnings limitations which vary according to the type of benefit. Industrial injury benefit is payable for a period not exceeding six months for incapacity, arising from an industrial accident of a prescribed industrial disease. When injury benefit ceases, disablement benefit is payable if there is still loss of faculty, and this can be paid whether or not the claimant is working. Similarly, the basic war disability pensions are payable without regard to the earnings of pensioners. Recipients of both these pensions may be entitled to supplementary benefits in certain circumstances. If these supplements include an unemployability allowance, pensioners may earn up to £52 per annum net without their allowances being affected. Persons in receipt of sickness benefit may earn up to £1 per week on remedial employment without loss of benefit. Anyone in receipt of National Assistance (other than persons in the regular employment field) may earn up to £1 per week without it affecting their allowance, only earnings in excess of £1 per week being deducted from the allowances.

228. The War Pensioners' Welfare Service, which is probably in touch with a greater number of homeworkers than any other body, has found that the real need of its homebound pensioners is for the provision of a diversionary occupation which, while providing at least some financial return, is chiefly beneficial for the mental and physical stimulus which results from engaging in a useful occupation which can be taken up and put down at will. A number of organisations have also stressed the benefit to be derived from occupational homework which engages the attention, produces a useful range of goods and makes a welcome addition to income. The Committee recognises these benefits and RECOMMENDS that local authorities should be encouraged to exercise their powers under Section 29 of the National Assistance Act to provide occupational homework as widely as possible either directly or through voluntary organisations. As local authorities compile their registers of disabled in need of help of this kind they will be in a better position to determine the nature of the problem and they may also find it easier to provide suitable forms of occupation. The Committee would like to stress how desirable it is to bring the disabled homeworkers as much as possible into social contact with the outside world and with each other as, for example, by having periodical sales of products or regular social evenings. It is believed that this is an aspect of welfare of the homeworker equally as important as the occupation itself. The Committee believes that at present a strong deterrent to the exercise of permissive powers by local authorities is the lack of any grant from exchequer funds, and this is one of the reasons for the recommendation in para. 124 that local authorities should be grant-aided for expenditure on welfare services.

(2) **Remunerative home employment**

229. Either because of the nature or severity of the disablement or because employment is not available within a reasonable travelling distance, some disabled persons will be capable of earning their livelihood only if suitable facilities can be provided for home employment. The main agencies are local authorities, voluntary organisations and Remploy Limited.

230. Remploy Limited operates a homeworkers employment scheme for about 130 home-bound persons who are capable of employment at home. There has been little development of homeworkers' schemes for severely disabled sighted persons within the employment field by either voluntary organisations or local authorities. In respect of such schemes the Ministry of Labour can give limited financial assistance towards the cost of administration of homeworking schemes and also towards the cost of capital equipment or accommodation required. Homeworkers' schemes covering 1,400 blind persons have been developed by local authorities and voluntary organisations. They cater for blind persons who for one reason or another cannot or do not wish to be employed in ordinary industry or in workshops for the blind. These homeworkers are usually in business on their own account and are assisted in obtaining raw materials, in the marketing of products, and with technical advice, and what follows in paragraph 231 does not apply to the blind.

231. The Committee believes that in making strenuous attempts to command a living wage the disabled person may well work long hours in conditions which are deleterious to health. The fact that "home work" ordinarily means "hand work" implies that in an increasingly mechanised world the range of goods which can be economically made at home is very narrow. It consists either of toys, lampshades, baskets, etc., for which local demand soon becomes exhausted or of assembly or similar work involving heavy overheads of distribution, supervision and collection, sometimes at prices which are quite disproportionate to the amount of time and effort devoted to the work. The Committee would not wish to belittle the value of occupational activities by which it is believed that the lives of many badly disabled people have been made considerably brighter, but in the Committee's opinion it would be unwise to imagine that there is a vast untapped source of work only waiting to be exploited. Apart, therefore, from the homework which would be more properly termed "work on own account" because it consists of a one-man business in boot repairing or some similar trade, it is unlikely that more than a limited number of homebound disabled persons will be able to earn a reasonable living from home employment.

232. From evidence received and from information obtained from organisations and persons who are engaged in the provision of homework, it is obvious that success in running home employment schemes is difficult to achieve. All existing schemes, with the exception of those covering the blind, appear to be on a very small scale and largely dependent on the initiative and painstaking work of a few outstanding organisations. Even in these circumstances many of the schemes incur considerable losses.

233. In these circumstances whilst the Committee RECOMMENDS that existing schemes of homework to provide remunerative employment should be continued and if possible developed (including those run by Remploy Limited in connection with its factories), it urges that much more consideration should be given to the alternative of bringing disabled workers to their work, rather than the reverse. It has been represented to the Committee that, particularly in outlying areas, distance from suitable employment or lack of transport facilities may be the primary reason for justification of homework rather than the serious nature of the disability. The Committee urges those concerned to consider how far systems of transport, similar to those which it is understood are at present being operated increasingly by factories which would not otherwise meet their labour requirements locally, could be extended to cover disabled persons, either in association with any existing transport schemes or separately as the need arises.

234. Where, because of the severity of the disability, work in ordinary industry would not be appropriate, it is suggested that transport, where necessary, should be provided to take the disabled to a sheltered workshop, where one is within reasonable daily travelling distance. The Committee notes in this connection that under Section 15 (4) of the Disabled Persons (Employment) Act there are powers which allow of the payment of travelling expenses incurred by persons travelling to and from sheltered work.

(3) **Possible restrictions on the expansion of homeworking schemes**

235. In evidence given to the Committee some emphasis was laid on homeworkers being deterred from working to their full extent because if they earn £1 a week or more they are required to pay the full national insurance contribution as self-employed persons, and while working as such are not entitled to sickness benefit. Any earnings in excess of £1 per week are taken into account in considering the amount of national assistance allowance to be paid.

236. In regard to the first deterrent, it is understood that it would be very difficult administratively to vary the amount of the weekly contribution according to the amount earned or the amount of work performed, and the Committee accepts the principle that there should be a uniform rate of contribution for self-employed persons, whatever the circumstances in which the work is carried on.

237. So far as sickness benefit is concerned, the Committee considers that the earnings permitted to a person certified as incapable of work and receiving sickness benefit should be such as to cover only purely remedial work. In the Committee's view, the limit of up to £1 a week which can be earned from such work without affecting sickness benefit is adequate for this purpose.

238. It was also suggested in the evidence that there should be an increase in the amount of earnings (£52 a year net) which can be disregarded in determining whether a war or industrial injury pensioner is capable of work for the purpose of the unemployability supplement. As in the case of sickness benefit to which somewhat similar considerations apply, the Committee does not consider that in practice the figure is proving to be too low. But in view of the continuing tendency for the purchasing power of money to decrease, and in view of the increase in the insurance contributions payable by self-employed persons the Committee is of opinion that a careful watch should be kept by the departments concerned to ensure that figures are in due relation to the conditions obtaining at the time, and that they provide sufficient elasticity.

239. Some evidence was received recommending a sliding scale for the earnings allowances of those in receipt of national assistance. A general rule of this kind, applied to all the many classes of persons in receipt of national assistance, could result in the composite income derived from allowances and earnings being comparable with or greater than the earnings of a person in full-time unskilled work. In any case the evidence received suggests that very few disabled persons are, in fact, discouraged from working by the present regulations. The Committee is unable, therefore, to recommend any general alteration of the kind proposed, but it thinks that there might be some cases where the Board would be justified in exercising the discretion which the Statutory Regulations give them to vary the amount of the earnings allowance so as to provide encouragement where it is most needed: where, for example, a homebound disabled person is endeavouring to build up a livelihood and is likely to be discouraged in the initial stages by his inability, so long as he remains in receipt of assistance, to better his position by more than £1 a week.

CHAPTER X. CATEGORIES OF DISABLED WHERE SPECIAL CONSIDERATIONS APPLY

240. Whilst the provisions for rehabilitation, training and resettlement are intended to be comprehensive and available to all disabled persons, the Committee thinks it desirable in this chapter to deal with special features affecting the following classes of disabled:—

(1) the young disabled;

(2) ex-service disabled;

(3) other disabled persons with disabilities involving special features

(*a*) the blind,

(*b*) the tuberculous,

(*c*) paraplegics,

(*d*) the mentally ill and mentally defective,

(*e*) spastics,

(*f*) epileptics,

(*g*) the deaf.

(1) The young disabled

(a) *Educational Provisions for Handicapped Children*

241. One of the duties of local education authorities is to provide special schools or special educational treatment for handicapped pupils whose disability makes it impossible for them to follow the normal régime at an ordinary primary or secondary school. If attendance at an ordinary school is not possible because of the nature of the child's handicap, arrangements may be made for attendance at a day or boarding special school. In January, 1955, there were 743 special schools in England and Wales, with a total of over 58,000 pupils. Local education authorities were also educating 1,820 handicapped pupils at suitable independent schools and were providing home tuition for a further 2,000. Arrangements for the education of children in hospitals are made by the provision of hospital special schools in those cases where the number of long-stay child patients warrants it. In other hospitals, arrangements are made and teachers sent in as necessary under Section 56 of the Education Act, 1944, which empowers authorities to provide education otherwise than at school. In January, 1955, there were 120 hospital special schools with nearly 6,500 pupils (included in the total number of special schools and pupils already given). In addition, over 1,400 children were being educated in hospitals where there was no special school. The arrangements for the provision of education for handicapped children in Scotland are substantially the same as in England and Wales. In 1955, 10,117 handicapped children in Scotland were attending 88 special schools (82 public and 6 grant-aided) or the special classes attached to 31 ordinary schools; 1,188 were receiving education in 46 hospitals; and about 300 were being given home tuition by education authorities. In England and Wales and in Scotland there has been a considerable expansion in the 10 years since the war in the facilities available for the education of handicapped children both in and out of hospital.

242. The upper limit of compulsory school attendance for handicapped pupils in ordinary schools as for all other pupils is 15 years. For pupils at special schools, the upper limit is 16 years. Most handicapped pupils leave special schools at 16, but in a few special schools, as in some ordinary schools, pupils may stay on to 18 or 19 years of age.

243. The education departments approve certain courses of further education and vocational or other training for blind or physically handicapped boys and girls who have left school. In January, 1955, there were in England and Wales 258 blind and 165 physically handicapped persons attending these courses.

244. The importance of every boy or girl being given the fullest opportunity of benefiting from educational facilities and subsequent training to fit them for employment is generally recognised and accepted. For disabled young persons it is not only important but essential that there should be adequate facilities to assist them in overcoming the handicaps which disability will impose upon them, particularly when reaching adult age.

245. The main requirements for the younger disabled are: (1) identification and assessment of disability, (2) adequate medical treatment, (3) education during prolonged periods of sickness whenever the state of the child's health permits, (4) special facilities for those disabled children who are unable to take advantage of ordinary educational facilities, (5) vocational guidance and careers advice towards the end of the normal period of education.

246. The Committee received no evidence to suggest that the existing arrangements are not generally adequate to ensure that all handicapped children are made known to the authorities. The Committee was told of particular instances where disabled children had not been identified, but it would seem inevitable that, no matter what the arrangements, the needs of a few children may remain unknown. Nevertheless, it is suggested that the responsible authorities should continue to exercise constant vigilance in order to ensure that the existing machinery is used to its full extent. If this is done, the Committee is satisfied that compulsory registration of disabled children would not be more effective in operation. The Committee accepts that the school medical services provide adequate facilities for medical assessment in all state provided schools, and that the National Health Service provides the necessary medical treatment.

247. So far as the education of handicapped children is concerned, immediately after the war there was a serious shortage of special school provision for most types of handicap, but this is no longer the case, although there are still some shortages, particularly for the educationally sub-normal. These shortages are in process of being made good as part of the educational building programme. In the field of hospital education, if local education authorities are adequately to discharge their responsibilities, the Committee RECOMMENDS* that (1) local education authorities should ensure that hospital authorities know what facilities can be provided for children in hospitals; (2) hospital authorities should arrange to bring to the notice of local education authorities the particulars of children in hospitals for whom educational arrangements should be made; (3) local education authorities should also make periodical enquiries of those hospitals likely to have young patients requiring education so as to ensure that the education of long-term child patients is not overlooked. The Committee recognises, however, that a child is in hospital for medical reasons and, although educational facilities for long-term patients are important, the decision whether a child can be given education in a hospital is essentially a matter of medical opinion.

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* The Committee is aware that circulars, the most recent of which is dated September, 1956, have been issued to local education authorities and companion memoranda to hospital authorities, stressing the importance of close co-operation in making educational facilities available for hospital patients.

(b) *The Youth Employment Service*

248. The Youth Employment Service, provided by local education authorities or the Ministry of Labour and National Service under Part II of the Employment and Training Act, 1948, makes vocational guidance and assistance in finding suitable employment available to all handicapped young persons at the school-leaving stage, and subsequently to the age of 18 years, is desired.

249. The service to the handicapped operates on the same general principles as that for other young persons. The needs of the handicapped, however, create special problems for the youth employment officer, and the Central Youth Employment Executive has issued a comprehensive memorandum of guidance on the Youth Employment Service and handicapped young persons.

250. Where at the school-leaving stage a disability exists, the school obtains from the School Health Service, or from the school's own medical officer in the case of an independent school, a medical report in prescribed form, indicating types of employment for which the young person would be unsuitable. This medical report is sent to the youth employment officer at the same time as the school-leaving report. On the basis of this information and of the aptitudes of the young person in relation to available work the Youth Employment Service assists the placing of those disabled young persons who call on it for assistance.

251. It was represented to the Committee that many disabled young persons were not, in the present favourable circumstances, finding it difficult to secure employment on leaving school, but that often this employment was either not suitable for them or was unlikely to lead to suitable employment in later years. The Medical Research Council Mem. No. 28 "Employment Problems of Disabled Youth in Glasgow" by Professor T. Ferguson, Dr. A. N. Macphail, and Margaret I. McVean, suggested that energetic steps should be taken to secure satisfactory resettlement before a young person begins to drift, and in this connection the Committee wholeheartedly supports the conclusion that "the ideal time for successful settlement is when the child leaves school, for if he is allowed to drift for even a short while at this stage his demoralisation is apt to be fatally easy and swift". The Committee thinks that the youth employment officer should be particularly diligent during the critical period of the first three months after leaving school, as any delay in getting the right job at this stage enhances the temptation of comparatively high wages which are readily available for a number of "blind alley" jobs. The youth employment officer has a most important role to play for all school leavers, but the need for particular care and attention in the initial careers advice and placing of the disabled before they leave school is vital. For disabled young persons, placing alone is not sufficient. The youth employment officer should undertake a systematic and meticulous follow-up of all placings of disabled young persons so that as far as possible he can ensure that they are in suitable employment and do not drift to unsuitable work. At the same time it is worth noting that the field of the youth employment officer is limited, as a substantial number of disabled school leavers do not use the facilities offered by the Youth Employment Service and do not register as disabled persons although eligible to do so. This partly accounts for the limited use at present made of vocational training provisions. The Committee has heard the view expressed that some form of compulsion should be used to ensure that the young disabled take advantage of the employment service which is available for them. No doubt they would benefit from a wider participation in vocational guidance and

training, but the Committee hopes that the aim in view could be more satisfactorily achieved if the attention of schools, parents and others concerned could be drawn to the importance of disabled young persons getting adequate vocational preparation to improve their employment opportunities in later life.

252. Some of the evidence suggested that special schools should have a specialist resettlement service to deal with the particularly difficult problems associated with the placing of special school leavers. The Committee notes that the normal careers advice and placing service for school leavers is also available for special school leavers and as this service should be able to provide all the necessary facilities it is considered unnecessary and undesirable to create new machinery for special schools alone.

253. The Youth Employment Service is responsible for the placing in employment of all young persons who come to it for help. Evidence stressed the need for the closest co-operation between this service and the schools. Whilst the Committee believes this co-operation to be generally satisfactory it is of especial importance in the case of the disabled, and the Committee considers that, at all times, both where the Youth Employment Service is run by the local education authority and where it is run by the Ministry of Labour, close co-operation should be maintained. It is also essential, in the Committee's view, that there should be co-operation between the youth employment officer and the disablement resettlement officer. The Committee was pleased to note that action had recently been taken to encourage personal contacts and the interchange of information between these two sets of officers. Arising from the provision for the disabled made in the employment service of the Ministry of Labour, the suggestion has been made that the Youth Employment Service should also have specialist officers to deal with the disabled, and even with particular types of disabled. Although it is understood that two or three local education authorities operating the Youth Employment Service in large urban areas with fairly large concentrations of disabled young people have found it of advantage to appoint a specialist officer of this type, the Committee does not accept this view for general application, first, because it will be rare for any youth employment officer to have enough disabled young persons in his area (usually a local education authority area) to justify such a designation and secondly, because this officer should rely for advice on specialist matters on those who are readily available and well qualified to give help where it is needed.

254. It is important that the youth employment officer should have close contact with the local authority welfare department so that disabled school leavers and other young persons in need of welfare services can easily be referred to the local authority for necessary assistance in the welfare field.

(*c*) *Disabled Persons* (*Employment*) *Act*

255. Where a disabled young person needs assistance in finding suitable employment, or where any of the other facilities available under the Disabled Persons (Employment) Act are required, including training in a government training centre, or elsewhere, the youth employment officer may consult the disablement resettlement officer of the Ministry of Labour and National Service in his area. In addition, he is advised to do so wherever this specialist officer's knowledge and experience might be of value to him, and in some areas he can refer " problem cases " to the nearest industrial rehabilitation unit for expert vocational guidance, though the ultimate responsibility for giving vocational guidance lies with the youth employment officer.

256. Training of disabled young persons can be undertaken both by local education authorities and by the Ministry of Labour. The education authorities can provide full-time education for disabled young persons over the school leaving age of 15, and they are also responsible for the provision of any part-time further education which may be required by young persons after leaving school. The Ministry of Labour and National Service can provide vocational training and industrial rehabilitation facilities under the Disabled Persons (Employment) Act for young persons over the age of 16. In addition the Employment and Training Act, 1948, enables both types of facility to be provided for persons above the upper limit of the compulsory school age, though the latter powers have not so far been used in relation to either disabled or able-bodied young persons below the age of 16 years. There were 73 disabled young persons aged 16–18 in training under the provisions of the Disabled Persons (Employment) Act on 23rd July, 1956, of whom 20 were taking courses at institutions of further education under arrangements made by the Ministry of Labour with local education authorities. On the same date 64 young persons aged 16–18 were attending industrial rehabilitation courses provided by the Ministry of Labour.

257. Some evidence was received deploring the "gap" between the normal school leaving age and the minimum age of 16 years for the provision of vocational training and industrial rehabilitation under the Disabled Persons (Employment) Act. There is no "gap" in the case of special school pupils, as attendance at these schools is compulsory up to the age of 16. Although in the case of normal school leavers it is not thought that the "gap" gives rise to many difficulties, the Committee RECOMMENDS that the school leaving age should be made the minimum age for the provision of vocational training and industrial rehabilitation under the Disabled Persons (Employment) Act.

(2) Ex-Service Disabled Men and Women

258. The statutory services cover all disabled, whether ex-service or not and whether the disability is congenital or due to injury or disease. The Disabled Persons (Employment) Act, 1944, gives certain priorities in training and resettlement to the ex-service disabled and provides for the automatic registration of 1914–18 war pensioners for so long as their pensions continue. On 16th April, 1956, of the 798,279 persons registered as disabled 436,166 were recorded as ex-service personnel (123,061 were 1914–18 pensioners). Of the 436,166 ex-service registered disabled persons, 18,906 were registered as unemployed.

259. After the first world war the King's National Roll Scheme was introduced in order to assist in the resettlement of disabled ex-servicemen. Employers were invited to employ a percentage, normally 5 per cent. of disabled and could then have their names placed on the King's National Roll. This scheme is still in operation for 1914–18 pensioners but, as the number of these has diminished with the passage of time, employers are now rarely enrolled, but if an employer undertakes to employ the required number of 1914–18 pensioners as they become available he is given a special certificate. The Committee is aware that the Disabled Persons (Employment) Act is much more comprehensive in its scope than the King's National Roll, but it would not recommend that the scheme should be terminated so long as it may be providing some assistance for the rapidly diminishing number of 1914–18 pensioners within the employment field.

260. Hospital treatment for ex-servicemen is provided through the National Health Service as well as at a small number of special hospitals for war

pensioners administered by the Ministry of Health. In addition artificial limb and appliance centres are provided by the Ministry primarily to meet the special needs of war pensioners in this respect.

261. The special welfare service of the Ministry of Pensions and National Insurance for all ex-service pensioners is mentioned in Chapter IX.

262. In the voluntary field, some organisations are concerned solely with the interests of ex-service persons or their families, and many regimental associations and benevolent funds take an active interest in their ex-service personnel, especially in the resettlement of their disabled. Some organisations have set up special workshops or training schemes specifically for the ex-service disabled.

263. The Committee has received relatively little evidence dealing specifically with the resettlement problems of the ex-service disabled. It appears that the normal provision for the rehabilitation, training, and resettlement of disabled persons, coupled with the generous help given by voluntary societies or organisations, and the War Pensioners' Welfare Service, ensures that the particular needs of the ex-service are kept well to the fore.

(3) **Other disabled persons with disabilities involving special features**

264. Whilst as a general principle all disabled persons, no matter what the nature or origin of their disabilities, should be able to enjoy similar resettlement facilities, there are sometimes features of certain disabilities which necessarily call for some modification of the normal or standard arrangements. In the following paragraphs reference is made to special features of this kind in relation to certain disabilities.

(a) *The Blind*

265. The statutory provisions covering the blind are described in Chapter IV, paras. 102–105. Fairly complete statistics of registered blind persons are available and these give a good indication of the size and nature of the problem. Thus in England and Wales on 31st December, 1955, there were 94,683 registered blind persons and in Scotland on 1st April, 1955, there were 9,742. In England and Wales 6,119 blind persons were in employment under ordinary conditions ; 3,108 in sheltered workshops, 1,268 as homeworkers and 504 in training for employment. Of the remaining registered blind persons 1,099 who were thought to be capable of employment, either with or without training, were unemployed. The corresponding figures for Scotland were: ordinary employment 255, sheltered employment 734, in homework 44, in training 123 and unemployed but capable of employment 185. In considering the rehabilitation of the blind it is important to note that over four-fifths of the newly blinded are over age 60 and nearly three-quarters are over 65.

266. Sheltered workshops for the blind are considered in Chapter VIII, para. 200 and homeworking schemes for the blind are mentioned in Chapter IX, para. 230.

267. The possibilities of employment for the blind under ordinary conditions were surveyed by the Working Party on the Employment of Blind Persons as recently as in 1951. The report of this body drew attention to the wide range of occupations in ordinary employment in which the blind could be suitably employed and emphasised the need for an effective rehabilitation, training, and placement service which would lead to an increase in the number of blind engaged in professional, commercial and industrial employment. In its report the Working Party noted the valuable work done by the voluntary organisations for the blind.

268. Among the recommendations of the Working Party was one for setting up a pilot establishment for blind adolescents to provide them with a general course of further education, and to give them some practice in a variety of skills, to provide them with vocational guidance and, above all, to encourage their social development. The Committee is glad to learn that such an establishment has recently been opened by a voluntary society after close consultation with the Ministries of Education and Labour. This establishment has no bias either for or against sheltered as opposed to ordinary employment, but aims at making it possible for each boy or girl who attends to make a sound choice of career on leaving. This development is of special importance because during his most formative years the blind person can be prepared for a career on the basis of the best possible assessment of his aptitudes.

269. Another recommendation of the Working Party was that newly blinded persons should have the opportunity of attending residential establishments so that they could become adjusted to blindness, learn how to adapt themselves to new social and economic circumstances, and be assessed for the kind of subsequent employment most suitable for them. The Committee is aware that opinions differ as to the necessity in every case for residential rehabilitation of the kind provided by voluntary societies. While the services made available by local authorities through home teaching and in other ways play a valuable part in giving the blind person confidence and encouragement in the new circumstances of living, the Committee considers that many newly blinded persons particularly younger people, would benefit by the more comprehensive facilities which can be provided at a residential establishment.

270. Two forms of rehabilitation are available in these establishments, distinguished as social and industrial. Social rehabilitation is solely directed to the adaptation of the blind person to the ordinary processes of living. Industrial rehabilitation, while including this, is also directed towards the resettlement of the blind person in employment, often of a different kind from that in which he was engaged before the onset of blindness. For those persons needing only social rehabilitation, a local authority may make a contribution towards the cost of maintaining a blind person at the rehabilitation centre. In respect of industrial rehabilitation, the Ministry of Labour and National Service pays fees to the body responsible for providing the centre and maintenance allowances to the persons undergoing rehabilitation. Blind persons coming forward for social rehabilitation only will normally be outside the field of employment and therefore the scale of maintenance allowances should be differently based. The Committee RECOMMENDS that expenditure incurred by local authorities upon social rehabilitation in this way should rank for the grant recommended in paragraph 124 above. The effect of such a provision will probably encourage local authorities to make greater use of the facilities.

271. The Committee is pleased to note that in recent years, as the result of better rehabilitation and training facilities for the blind, a greater number of blind persons has been securing employment in ordinary industry than in sheltered workshops. This trend is welcomed, but if it is to continue effectively it is important that there should be a fully adequate service for placing the blind in such work.

272. In its report the Working Party emphasised the need for a specialist placing service for the blind and urged that local authorities should exercise their powers either to undertake this work themselves or to do it through a voluntary organisation. The present position is that in England and Wales

the long established services run by two local authorities have been continued; in some areas the local authority is using a voluntary association for its placing work; and in some other areas local authorities have taken on the work themselves as a part of their welfare services. In Scotland, no local authority or voluntary organisation has so far embarked on a placing service. We understand that recently a Ministry of Labour officer has been specialising in the placing of the blind in ordinary industry in the west of Scotland with some success; in other areas, the disablement resettlement officers give what assistance they can in finding work for the blind.

273. Whilst the Committee sees the force of the suggestion that a specialist placing service is necessary for the blind, the application of this principle under existing arrangements has led to the present patchwork of administration of placing services which may well have had the effect, over the country as a whole, of providing a service for the blind inferior to that available for other classes of disabled. In any case there is much advantage in having someone locally to whom the blind may turn for assistance from day to day, however much this assistance may be supplemented by specialist officers. The Ministry of Labour has a general responsibility for securing employment for all classes of disabled persons and the Committee RECOMMENDS that this Ministry should assume full responsibility for ensuring that the placement of the blind is put on a satisfactory footing, and should itself normally provide a placing service, thus relieving local authorities of the responsibility at present assigned to them. At the same time it is recognised that several local authorities are operating efficient placing services for the blind and that in some other areas local authorities are using the services of voluntary organisations with good effect. Without derogating from the Ministry of Labour's complete responsibility, the Committee thinks that arrangements might be made for local authorities and voluntary organisations at present carrying out the work satisfactorily to continue to do so if they wish, at any rate for the time being. Only by such integration of the placing services for the blind in one department does it seem possible that a fully effective service can be given, and the Committee does not doubt that any necessary specialisation can be introduced into whatever arrangement is adopted.

(b) *The Tuberculous*

274. Some indication of the size of the problem of the resettlement of handicapped persons suffering with respiratory tuberculosis can be gauged from the statistics of chest clinic registrations. The total on the chest clinic registers for England, Wales and Scotland in the year ending 31st December, 1955, was 356,645. It is understood that a name remains on the chest clinic register for five years after notification of the disease. The register will, therefore, at any time include a number of persons well on the road to recovery and many more who are actually in employment. On the 18th April, 1955, 58,555 persons suffering from respiratory tuberculosis were registered as disabled under the Disabled Persons (Employment) Act and of this number 2,890 were registered as unemployed.

275. The Committee's recommendations on sheltered employment for the tuberculous will be found in Chapter VIII. Two County Councils provide workshops for ex-patients and two County Councils administer rehabilitation colonies for the tuberculous. In addition, sheltered employment facilities for the tuberculous are also provided in colonies and in workshops run by voluntary organisations. The Ministry of Labour and National Service makes grants in respect of the training facilities and, in special circumstances, for employment facilities. Local authorities are expected to contribute

towards the cost of after-care provided for their own applicants. Sheltered employment for the tuberculous only is also provided in several special Remploy Factories.

276. Though modern methods of treatment and prevention are steadily producing striking results tuberculosis is recognised as a disease presenting special difficulties. As the British Medical Association said in its evidence, there are three features of tuberculosis, namely "its infectivity, the long convalescence and the liability of the patient to breakdown (which) necessitate the adoption of special methods of resettlement. The basic principle must be that the ambulant chronic patient shall be employed to his fullest capacity".

277. The spending of long hours of forced physical inactivity either in hospital or at home is an outstanding feature of this disability. It is important, therefore, as has been pointed out in the evidence submitted, that the patient should be given, within his capacity, some occupation often mental rather than physical, which will engage his attention and help considerably in his recovery. Conclusions relating to the education of children in hospital or sanatoria will be found in the section on disabled youth (para. 247). So far as adults are concerned, the Committee found that in some hospitals provision was made through local education authorities or otherwise to give patients an occupation, not uncommonly one which consisted of study with a view to employment when recovery was complete, but this practice does not at present appear to be as well known or as widespread as it should be. It is the joint responsibility of the hospital and education authorities to meet the needs of adult patients, and it is RECOMMENDED that hospital authorities should approach the education authority with a view to introducing educational facilities of a suitable kind wherever possible. An encouraging example of this kind is the arrangement by which students who have had their studies interrupted by tuberculosis are given the benefit of tuition whilst they are recovering in a rehabilitation unit specially reserved for them. The Committee is glad that the local education authority in the area where the centre was opened has found it possible to assist in meeting the financial cost of the venture.

278. As recovery continues the Committee thinks every opportunity should be taken of extending the range of activities, including those requiring physical effort, and when the tuberculous patient is capable of working for three or four hours a day a much more ambitious programme of activities should be attempted. Often at this stage the patient will have returned home and representations have been made that part-time vocational training courses ought to be provided for those who need them and are able to undertake them. Although there are obvious difficulties in providing such training, the Committee is glad to note that the first effort of this kind, outside the special settlements, which are referred to later, has recently been embarked on at a government training centre in the West of London. The Committee RECOMMENDS that in conjunction with chest clinics, the Ministry of Labour should inquire in other parts of the country from time to time to ascertain whether similar facilities might be introduced. It is understood that at certain government training centres it has also been possible to make individual arrangements for part-time training to meet particular needs. The Committee is interested to note that about 25 per cent. of all those attending industrial rehabilitation units are ex-tuberculous patients as are about 30 per cent. of those in full-time training at government training centres.

279. Many tuberculous patients will return to their former employment, and may not find any special difficulty in doing so. For those, however,

who are not able to return to their former employment or to work of a similar kind (and this particularly applies to manual workers) the prospects of early employment are much reduced. It is particularly for such persons that close co-operation between chest physicians and disablement resettlement officers is necessary, in the first place to assess the capacity of the patient and then to consider what suitable employment can be found for him. This is particularly necessary in relation to tuberculosis because of the grave risk that tuberculous persons will find their way back into unsuitable work, run risks themselves and be a danger to their fellow workers. The Committee was glad to note that an explanatory leaflet on the rehabilitation services available was issued to chest physicians in May, 1956.

280. It is understood that it has been generally agreed that infection in itself need not be a bar to the employment of tuberculous persons if adequate precautions are taken in regard to the kind of work to be done, the circumstances in which it is done, and the conduct of the tuberculous person himself. A procedure which takes account of these factors is in operation, but, understandably, comparatively few persons are placed in work in these conditions. The Committee is satisfied that such a procedure should continue and that if the infectious person is quite capable of performing a day's work he should be given the fullest opportunity of doing so, subject to proper safeguards. In this connection the Committee is pleased to note that many hospital authorities are giving employment in sanatoria to tuberculous persons.

281. In this country, as perhaps in no other, a few village settlements have been established at which persons suffering from tuberculosis may, whilst still convalescent, take up vocational training on a graduated basis under medical supervision enabling them to continue in employment either in the village settlement itself or, if they are sufficiently recovered, in outside industry. A noticeable feature of these schemes is that rehabilitation is provided while training proceeds so that at the end of a year or two the trainee is usually capable of earning his own living. The number of tuberculous persons who can be dealt with in these village settlements is, of course, limited, and some evidence was offered that schemes of this kind had now served their purpose. In the Committee's view, however, the colonies can continue to do useful work, particularly in training for outside employment persons still in the infectious stage of tuberculosis.

282. By no means all tuberculous persons, whether suitable for such settlements or not, are willing and able to go to them, and the Committee has been told by several organisations that there is an established need for the provision of hostels to accommodate those tuberculous persons whose home circumstances are unfavourable or for whom suitable employment cannot be found in their home area. One or two local authorities provide special hostels for the tuberculous and the Committee RECOMMENDS that more hostels of this kind should be established where they are found to be necessary.

283. Some of the evidence suggested that there was a tendency for tuberculous persons to remain without work and in receipt of sickness benefit or other payments longer than was really necessary, partly because medical practitioners were not fully aware of the possibilities of rehabilitation and resettlement, and partly because tuberculous persons might hesitate to undertake work which they might regard rightly or wrongly as prejudicial to their health. No very precise information was given on these matters and the Committee RECOMMENDS that some enquiry should be made on the basis of chest clinic registration, to ascertain how far there are any

appreciable numbers of ex-tuberculous patients remaining unemployed, who, given the proper measures of rehabilitation, might once again resume work.

(c) *Paraplegics*

284. Special spinal units for the treatment of paraplegics have been set up at Stoke Mandeville Hospital and elsewhere. At these units remarkable work has been done and immense strides have been made in the rehabilitation and resettlement of paraplegics. A review of 766 of the paraplegic war pensioners who had passed through the spinal injuries centre at Stoke Mandeville since its foundation in 1944 showed that more than 70 per cent. were in full or part-time employment. Not so long ago this disability, which involves paralysis of the lower limbs as the result of a spinal injury or disease, was usually fatal and those few who survived only did so to lead a life of invalidism. The Committee is glad to note the progress which has been made in both the treatment and resettlement of persons suffering from this disability.

285. The Committee thinks that it is particularly necessary for careful follow-up to be made of paraplegics after they leave hospital. This is understood to be the normal procedure and, for example, at the spinal injuries centre, Stoke Mandeville Hospital, the combination of medical supervision with a follow-up every six months is considered to be a most important psychological factor in maintaining the morale of these severely disabled persons. Many paraplegics with the aid of invalid tricycles or other transport have been able to take up work in ordinary industry.

286. Where paraplegics, on discharge from hospital, need special attention and accommodation (including accommodation for their wheelchairs) which cannot be provided in ordinary hostels or at home, or where there is no home to go to, there may be need for special hostel accommodation. The Committee is glad to note that there is such a special hostel known as Duchess of Gloucester House at Isleworth, Middlesex, with accommodation for 70 male paraplegics. Originally set up by the Ministry of Pensions primarily for ex-service men it is now run by the Ministry of Labour and National Service for civilian paraplegics as well. The men living in the hostel go out daily to work in local factories and offices. Although, because of the special facilities provided, the hostel has proved expensive to run the Committee considers the money well spent; the hostel has made it possible for paraplegics, who would otherwise remain unemployed and probably occupy hospital beds, to earn their livelihood in ordinary employment. Furthermore, the hostel has in a number of instances proved to be a stepping stone to other suitable accommodation where the paraplegics have become fully self-supporting members of the community. The Committee also commends the efforts which have been made by certain voluntary organisations to establish special settlements for paraplegics—at Lyme Green, near Macclesfield, Kytes near Watford and the Thistle Foundation Edinburgh—where paraplegics live with their families and engage in work either at home, in a sheltered workshop or in nearby industry.

287. Ideally, the Committee believes that paraplegics like other disabled persons should, wherever possible, live at home and go out to work, preferably in ordinary competitive industry, but if necessary in a sheltered workshop. Living conditions may have to be adapted to enable this to be done, and the Committee RECOMMENDS that local authorities and others concerned should give special attention to the needs of this special class by doing all they can through adaptations or otherwise to provide accommodation which is suitable for paraplegics.

(d) *Mentally Ill and Mentally Defective*

288. The mentally disabled give rise to special problems of rehabilitation and resettlement, not only by reason of their number and variety but also because of the special statutory provisions applying to them. The Royal Commission on the Law relating to Mental Illness and Mental Deficiency is considering the legal position in England and Wales, and their recommendations may well affect this Committee's field of work. The Committee has, however, necessarily taken as its starting point the present statutory requirements, and its recommendations are framed accordingly.

289. Nearly half the beds in National Health Service hospitals are occupied by mentally ill or defective patients ; but this fact by itself may exaggerate the problem. A high proportion of these patients is elderly (nearly one-third in mental hospitals are over 65), and others are long-term cases unlikely to become fit for discharge ; the number of mentally ill or defective patients discharged each year is about 3 per cent. of all discharges. Even this number, however, together with those treated as out-patients, represents a considerable problem of rehabilitation and resettlement. There is, in addition, the problem of providing so far as possible useful (and remunerative) employment for those who are unfit for discharge from hospital.

290. Apart from mentally disabled persons readily recognised as needing rehabilitation, the National Assistance Board and the Ministry of Labour come across considerable numbers of persons whose eccentricities or inability to settle down suggest that they too are mentally ill. On the other hand, people of this kind are often not recognised as needing psychiatric treatment and usually would not themselves admit that they needed it. As things stand, it is not easy to obtain the necessary advice for them because there is no machinery available to assess their needs. Their numbers are unknown and it is impossible even to make a rough estimate of them, but it is probable that those who are picked up by the various services represent only a part of those in need of help. The Committee has no doubt that this is a very difficult problem and one for which it is most unlikely that a completely satisfactory solution can be found. However, it is important that all those who are likely to come across individuals of this kind should be aware of their existence and that the departments concerned should ensure that their officers are given such information as may be possible as to how proper psychiatric advice can be obtained if the person can be persuaded to seek it.

291. The mentally disabled who have been identified and need rehabilitation can be classified as follows in groups which include both the mentally ill and mental defectives.

(*a*) Patients who have recovered from psychosis or neurosis, and high-grade mentally defective patients who have been socially trained and are employable. This group needs help—possibly including some vocational training—in getting employment, and may need help at home.

(*b*) Convalescent patients, whose recovery is not as complete as that of those in the first group, and who need expert rehabilitation preparatory to help in getting work.

(*c*) Neurotic or mildly psychotic patients, and medium-grade mental defectives or other defectives with residual instability, who are employable but need to live under psychiatric supervision and care.

(*d*) Deteriorated mental patients, and low-grade defectives, who must remain as in-patients of mental or mental deficiency hospitals but some of whom are capable of training and occupation in hospital workshops.

292. The first of the groups (*a*) presents no special problem. What is required is the same kind of help in resettlement, after-care and welfare as is generally available through the Ministry of Labour employment service and the local authority services. There is, however, a special need for close co-operation and links between the different services (such as the resettlement clinic or conference recommended in para. 57) which is emphasised elsewhere in this report.

293. The second of the groups (*b*) has special needs which call for further action. The Committee was impressed by the evidence of the value of an arrangement made between some mental and mental deficiency hospitals and industrial rehabilitation units, by which persons in this group have been given courses of industrial rehabilitation before discharge from hospital and have subsequently been satisfactorily resettled in employment. The Committee RECOMMENDS that the possibility of further arrangements of this kind should be considered more widely by hospitals and by the Ministry of Labour.

294. A further need of this group, brought to the Committee's attention in evidence by the Royal Medico-Psychological Association, is for hostels, in which they would live for a period on discharge while undergoing industrial rehabilitation or training, or on first entering employment. A hostel of this kind would serve as a bridge between institutional life and full life in the community and ease the transition from one to the other, and might well be provided by local authorities as part of their health or welfare services (as is in fact already done in one or two areas). It is important that any such hostels should not become second-grade mental or mental deficiency hospitals, and the residents would need careful selection. The Committee has it in mind that they should be discharged patients receiving any necessary medical care from their general practitioner, and not needing day-to-day psychiatric supervision or nursing, though they may from time to time attend a psychiatric out-patient department if necessary.

295. The Committee is not aware of any evidence showing how great is the demand for hostel accommodation of this kind ; but it is clear that only in the larger local authority areas would it be sufficient to justify the provision of a hostel, though smaller authorities would no doubt seek to join with the larger in making use of any available accommodation. The Committee RECOMMENDS that local authorities should be encouraged to experiment in the provision of hostels for this purpose.

296. The third of the groups (*c*) set out in para. 291 above differs from the second in that the members of it, while able to work in the community, are not fit for discharge from hospital care, though that care may well be better provided in separate annexes convenient to their work than in the main hospital itself. Accommodation of this kind is already provided by the hospital authorities in some areas ; the Royal Medico-Psychological Association in its evidence supported the extension of the principle, both for mentally ill and mentally defective patients ; and the Committee RECOMMENDS that hospital authorities should pay particular attention to this possibility in developing the mental and mental deficiency hospital services. It is, of course, a corollary of so doing that the hospitals and the Ministry of Labour employment service should work closely together in assessing the capacity for employment and the need for industrial rehabilitation or training of the patients concerned.

297. The fourth group (*d*) consists of those hospital in-patients who are capable of employment only in the sheltered environment of the hospital itself. The Committee has been interested to learn of the steps taken to provide simple factory work by arrangement with local industry. These experiments seem to be worthy and capable of extension to other hospitals, and the Committee RECOMMENDS hospital authorities to consider the possibility of doing so.

(e) *Spastics*

298. The Committee received a considerable amount of evidence on the needs of spastics (as persons suffering from cerebral palsy are commonly called), some of it suggesting that this condition was such as to justify the provision of special measures over and above those ordinarily available for disabled persons. No precise evidence was available as to the total number of spastics in the country and no national statistics exist. It appears, however, from various surveys which have been made into the incidence of cerebral palsy amongst children, that of the population aged under sixteen years, about one per thousand is handicapped in this way. As the expectation of life of many spastics is almost certainly less than that of healthy individuals, the number of adult spastics would be lower in proportion to the adult population than one per thousand.

299. Due, mainly to failure in the development of the brain, their handicaps arise from difficulty in movement and sometimes impairment of intellect but the degree of disability varies greatly between one spastic and another.

300. The Committee has considered carefully whether this condition is sufficiently distinct and different from other forms of handicap to justify the provision of special measures either of treatment, resettlement, employment or welfare. It may well be that because the spastic has to learn everything as a handicapped person from the start, he may need longer training at any stage than the person who became handicapped later in life. But the medical treatment required does not differ radically from that needed for camparable handicaps. Similarly, the measures for the education of the spastic do not appear to differ generally from those necessary for children suffering from severe handicaps of any kind. Furthermore, any special measures for spastics must, in the end, tend to isolate them needlessly from their fellows. There does not, therefore, seem to be any real ground for supposing that special measures over and above those ordinarily available for disabled persons are generally necessary or even desirable.

301. The Committee has no doubt that in the past there have been failures to assess the abilities and needs of spastics, either sufficiently fully or sufficiently early, so that as a result many children have received much sympathy but little practical help. Partly this arises from difficulties of diagnosis at a very early age but once the diagnosis is made, early and accurate assessment is the key to satisfactory education and settlement. The spastic child will almost certainly be known to the family doctor and very probably to the local health authority through the maternity and child welfare service. Through both of these the child can be quickly referred to hospital so that there should be no reason why facilities for assessment will not readily be available. There are, however, two social difficulties. The child's parents may for a considerable time be reluctant to face the fact that their child is seriously handicapped in this way. Furthermore, the natural instincts of the child's mother to protect can easily develop too far, so that she encumbers it with help. It is, therefore, of the greatest importance that the family doctor and the health visitor impress on the parents the need for early and accurate assessment and, if it is confirmed that the child is almost

certain to be seriously handicapped, to be ready to leave the parents in no doubt as to the many ways in which help can be given.

(f) *Epileptics*

302. Several witnesses, including the British Epilepsy Association, drew the attention of the Committee to the special problems of epileptics, particularly in the employment field. The Committee was informed that the Health Departments had received reports four years ago from their respective Advisory Councils on the welfare of handicapped persons about the welfare of epileptics, and that these reports had been sent to local welfare authorities for their guidance. In the later stages of its work the Committee had the advantage of the review made in the report to the Minister of Health on the Medical Care of Epileptics by a sub-committee of the Minister's Standing Medical Advisory Committee. Although essentially a review of hospital and other medical services, it also touched on some of the educational, employment and social problems of epilepsy, and constitutes a valuable assessment of present needs and future action.

303. The most important finding of the report is that recent advances in medical knowledge offer much greater hope that epilepsy can be controlled, particularly if they can be made generally and readily available through an organised pattern of specialist units as suggested in the report. The Committee is glad to know that action on these lines has been commended to hospital authorities by the Minister of Health. This means that it should be easier in the future than in the past for an increasing proportion of epileptics to live a normal life in the community, whether as schoolchildren receiving education in ordinary schools or as workers taking a normal place in open industry. Clearly this should be the objective. There must, however, be some proportion however small, who will need special provision whether for short or long periods, in the same way as other disabled persons—for example, special schools, rehabilitation units, sheltered employment, residential hostels, etc. Their needs require also the same close co-operation between the different authorities responsible for the different services which the Committee has emphasised elsewhere. In these respects no special comment is called for by this Committee on the problems of the epileptic.

304. Mention should, however, be made of one matter which while not constituting a difficulty peculiar to the epileptic, is more prominent in his case—namely, the difficulty of obtaining and retaining employment. The distress caused to witnesses of an epileptic attack, and the consequent interruptions and upset of work, do tend to create in the minds of employers and of the public generally an exaggerated idea of the disabilities of epileptics and of their unsuitability for employment. It is essential that the capacity and disability of the epileptic should be fully assessed when his condition has been controlled and information frankly exchanged between the doctor in charge of the case or the resettlement clinic and the disablement resettlement officer. The Committee is glad to note that it has been the long standing practice of disablement resettlement officers to get an epileptic to agree to the disclosure of his condition to his prospective employer and always to take special care in submitting an epileptic to employment, in introducing him to it and in giving the employer a full, frank statement of the position. The Committee is certain that in the long run this is to the benefit of all concerned, including those who are to work with epileptics.

305. However, there is still need for education of the public so that the variations in the degree of the disability are realised and in order that the public is made aware of the high proportion of epileptics who are only lightly handicapped. The Ministry of Labour has issued a valuable leaflet

addressed to employers advising them on matters affecting the employment of epileptics. Both the Scottish Epilepsy Association and the British Epilepsy Association provide information of a more general character directed to the education of the public in the nature of epilepsy.

(g) *Deaf, including the Hard of Hearing and the Deaf and Dumb*

306. Under Section 29 of the National Assistance Act many local authorities have made provision for the deaf (including the deaf and dumb and hard of hearing) by submitting special schemes for the welfare of this class of disabled. The special problems have long been recognised and, like the blind, this class is well represented by voluntary organisations which look after their interests and are actively concerned with their welfare. The deaf are often helped to obtain employment by these organisations who, through their local branches and the commissioners for the deaf, maintain close co-operation with the disablement resettlement officers in placing and resettling the deaf in industry.

307. Deaf or deaf and dumb children need special treatment and their disability gives rise to problems of medical treatment and of education. To meet these, special schools for deaf children have been provided for many years and, more recently, special educational facilities in normal schools. The tendency now is to make every effort to keep the child with a hearing handicap in a normal speaking community. The Committee wishes to emphasise that for the child with a hearing handicap, whether speaking or not, accurate assessment, auditory training and often provision of a hearing aid at the earliest possible age are of the greatest importance.

308. For older persons, deafness in itself is not normally a barrier to employment, although it might be a barrier to promotion or advancement. The rehabilitation and resettlement of the deaf and hard of hearing have been the concern of voluntary organisations for many years and the Committee commends the way in which they have provided facilities for assistthing this class of disabled person. In view of this it is thought that the facilities for their resettlement do not call for special comment in this report beyond stressing the importance of the continuance of the close co-operation of volunary organisations with official agencies. The Committee is pleased to note that the Ministry of Labour in co-operation with voluntary organisations has issued an explanatory leaflet designed to assist in the placing of the deaf and hard of hearing.

309. It is now recognised that suitable hearing aids should be provided for those in this class who can benefit from their use. It is also important that instruction should be given in the use and maintenance of hearing aids so that full benefit may be derived from them : the Committee understands that this is becoming increasingly available. With the initiation of the National Health Service in 1948 hearing aids became for the first time freely available to those likely to benefit from their use. A considerable demand was revealed which led to long waiting lists for the supply of aids. The Committee understands, however, that this demand has been overtaken that waiting is now negligible.

CHAPTER XI. ADMINISTRATIVE ARRANGEMENTS

310. Paragraphs 11 and 12 of this report outline the statutory provision for the disabled and show that the services in question, because of their differing nature and great extent, are necessarily provided and administered by different government departments or by local authorities. In Appendix I is reproduced a table showing the statutory services available to disabled persons and the authorities by whom they are administered. This may well

appear complex, especially to a lay person coming freshly to these matters. Reference is made later in this section to the recent issue of a booklet which sets out to clarify the position, and to act as a convenient guide to all who are professionally or otherwise concerned in disablement or rehabilitation.

311. It was to be expected that some of the evidence received would raise general questions on the administrative arrangements for services to the disabled; and this was the case.

(i) The leading thought in this evidence was that the division between several Ministries of the ultimate responsibility for rehabilitation of the individual (which should be a continuous process) means that there is no continuous expert supervision of the disabled person from the time of his entry into hospital until his satisfactory resettlement into old or new employment.

(ii) It was thought that among the numerous official agencies, overlapping and duplication must necessarily exist; and, at the local level, among those concerned and certainly among disabled persons and the public, there was confusion and ignorance as to the facilities available. Among remedies suggested were:

(iii) Closer collaboration between the various government departments concerned, and perhaps a clearer definition of each department's responsibilities.

(iv) That a single government department should take responsibility for ensuring that there are no delays in the progressive conduct of the disabled person's treatment and rehabilitation;

(v) That the departments concerned should set up a joint board consisting of representatives from the interested departments, the medical world, and both sides of industry, which should have the task of co-ordinating the work of rehabilitation; and finally:

(vi) That there should be a National Corporation for the Disabled.

312. The three suggestions last mentioned, viz. (iv), (v) and (vi), all deal with forms of co-ordination or concentration of services for the disabled, and the most ambitious is the last.

313. Taking these in reverse order: the proposed National Corporation for the Disabled was conceived as a body to be set up by the Government on lines somewhat similar to the British Broadcasting Corporation. The Corporation would work through regional committees, consisting of policy advisers directly responsible to the Corporation, together with representatives of the medical, social and industrial groups of the region. The regional committees would link up with the county committees for the handicapped, local voluntary organisations, local authorities, and presumably local representatives of the interested government departments. The individual handicapped person would be the responsibility of the Corporation from the moment of disclosure or notification of the handicap, throughout the necessary processes of education or rehabilitation until the final establishment or re-establishment in gainful employment. If subsequently the person became unemployed, he would then again be the responsibility of the Corporation. The Corporation would have power to call on all official services to help the handicapped person and to see that everything possible was done for him, and only when it appeared that the existing machinery both official and voluntary was not suitable would new developments be undertaken.

314. Apart from the inherent difficulty of deciding by what definition and at what point of time a disabled person would become the charge of

the suggested Corporation it does not seem to the Committee that in placing the responsibility for disabled persons on one body any more effective service for the disabled would be given. Indeed, there is reason to suppose that, by superimposing upon the existing services a body not itself directly involved in any phase of the work of rehabilitation, there would be duplication of consideration and delays in action at a high cost of administration. The conception ignores the fact that in nearly all cases the medical treatment, the education and the training of the disabled are necessarily bound up with similar services to the non-disabled. In addition, sickness and disability allowances are bound up with other social security benefits and the employment of the disabled is bound up with the employment of the able-bodied.

315. For similar reasons the Committee has not regarded suggestions (iv) and (v) above as practicable. There remain the questions ventilated under heads (i), (ii) and (iii).

316. As regards overlapping and duplication, an analysis of services for the disabled is set out in Appendix I. The Committee has already recommended some tidying up of administrative responsibility particularly in the sheltered employment field but it suggests that the question of overlapping and duplication might well be kept under regular review, perhaps by the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons referred to hereafter. The Committee received no evidence to suggest that at the operative level there is in practice much overlapping among the statutory services in the sense that the disabled person is likely to avail himself of two available agencies simultaneously for the same service.

317. As stated more than once in this report, the Committee is convinced that the present powers and administration offer all the facilities that are needed for the satisfactory resettlement of the disabled person. To secure the most efficient operation of these services (from the standpoint of the individual) at the minimum cost in manpower and money, sensitive contact and willing co-operation are necessary between the various agencies and departments concerned. This is needed at the centre, at the local level, and among the regional authorities. The Committee believes that some improvement in existing conditions at all levels may be desirable and is attainable.

318. Locally, there is room for an improvement in the state of information among professional official people, particularly the medical authorities caring for the disabled, as to the total range of facilities available. The disabled themselves, and the general public too, would benefit from better knowledge of these matters. The Committee has referred to the booklet sponsored by the Standing Rehabilitation and Resettlement Committee which has recently been published. For the benefit of the disabled person and his relatives and friends, an abbreviated and simplified version of this guide, which could be made available free of cost and circulated widely, would be of assistance in disseminating knowledge of the facilities available, and would promote the quick and efficient resort to them by those in need.

319. Improvement of information will not, of course, solve the residual problems of contact at local level between all the agencies concerned. Since the agencies are numerous and various, collaboration is essential to bring the benefits fully to bear and to secure as far as possible that there are no gaps in the individual's progress through the process of rehabilitation.

320. The Committee has considered whether some comprehensive formal machinery should be set up for the purpose.

321. It was suggested in evidence that local general co-ordinating committees should be established which would comprise representatives of the local health and welfare authorities, the National Assistance Board, the Ministries of Labour and National Service, and of Pensions and National Insurance, general practitioners, voluntary organisations, and, in some, all persons concerned with the health and care of disabled and handicapped persons. For this proposal the example was adduced of Finland. There, each municipality has a social committee elected by the communal council, which is responsible for all matters relating to social welfare. Finland is a small country with, for the most part, small communities; but, apart from the validity of the comparison, the Committee is inclined to doubt the general principle. It is doubtful whether the problems, such as they are, of co-operation between local officials and professionals concerned with the various aspects of rehabilitation, and of these with the organs of voluntary effort, can be solved by setting up an additional formal system of committees; and the Committee does not wish to recommend any new organisation of this sort. It prefers to rely upon a more spontaneous growth set up ad hoc. The Committee believes that the great advantages which can undoubtedly be obtained by fuller co-operation between local workers in the rehabilitation field, can best be developed by regular informal meetings of the people concerned to discuss current problems and difficult cases. This is happening in some parts of the country with success, and the Committee would like to see it extended. What is needed is the initiative to get such arrangements going, and the spirit of co-operation to make it successful. The initiative may well come from an individual or a voluntary association, a government department or a local authority; the Committee considers that in the last resort it should be the care of the local authority to encourage such meetings and to provide opportunities for them. The spirit of co-operation cannot be commanded; it should develop naturally with such encouragement from the headquarters of the departments and the voluntary organisations concerned as may be needed.

322. The efficiency of the arrangements made for the rehabilitation and resettlement of the disabled person depends, in the last resort, not on organisation so much as on the personal relations between the professional and official persons concerned—the general practitioner, hospital doctors, nurses and social workers, disablement resettlement officers, youth employment officers, teachers and the rest. Co-operation on this personal basis is, therefore, to be encouraged at all times amongst such people, who the Committee believes are carrying out their various tasks ably and conscientiously.

323. The Minister of Health, the Secretary of State for Scotland and the Minister of Labour have Advisory Councils which advise them on problems affecting the disabled. In the Ministry of Health and the Department of Health for Scotland the Council is concerned with the welfare services for the disabled provided under the National Assistance Act and the Ministry of Labour Advisory Council is concerned with the employment of the disabled. The Committee had the advantage of meeting representatives of these three bodies, which consist entirely of non-departmental members appointed for their concern and interest in the work. The composition of these Councils is shown in Appendix J. These Councils and their Committees provide valuable machinery for a continuous review of problems concerning the disabled and an opportunity for the expression of informed outside opinion with a view to advising the departments concerned.

324. The Ministry of Labour and National Service, the Ministry of Pensions and National Insurance and the National Assistance Board have also set up Local Advisory Committees to deal with local questions. Thus, there are

Disablement Advisory Committees to advise and assist the Minister of Labour in all matters relating to the employment of the disabled in their districts. In an executive capacity, these Committees also report on individual cases referred to them in connection with the operation of registration, quota and designated employment schemes and make recommendations to the Minister. Most of this executive work is delegated to Panels of the Committee. The Committee had the advantage of meeting representatives of some of these Committees. It was much impressed with the keen interest shown by the representatives in questions affecting the employment of the disabled and also by their evident desire to solve local problems. The Committee believes that this is typical of the valuable services given by members of these Advisory Committees and it is most desirable that these Committees should continue.

325. With regard to co-ordination among departments at the centre, meaning co-ordination on policy and in the solution of problems, an instrument already exists in the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons which was appointed in January, 1943, following a recommendation of the Tomlinson Committee. This recommended that "a Committee consisting of representatives of the Departments concerned should be established to co-ordinate the work of the Departments responsible for the many different aspects of the whole scheme of rehabilitation and resettlement of disabled persons and to secure some general supervision over its development and its administration." This reference states succinctly what is required to produce the requisite measure of co-ordination between departments and agencies in what is not only a complex, but an expanding, and, conceptually in many aspects a rapidly changing field. The Standing Committee which has been since its inception under the chairmanship of a Deputy Secretary of the Ministry of Labour and National Service, formerly Sir Harold Wiles and more recently Dame Mary Smieton, made an admirable report on 12th September, 1946, and another on 11th September, 1948. The Standing Committee has continued to meet regularly and has recently sponsored the booklet already mentioned in this section. The setting up of this Committee of Inquiry may have delayed the publication of further progress reports but the Committee considers that the reports enable all those concerned with the disabled to keep abreast of developments and achievements and hopes that the Standing Committee may go on to produce further surveys at regular intervals on the lines of its first and second reports. The bulk of the agenda for the Committee obviously must come from the Ministry of Labour and the Health Departments and the Committee thinks that, especially in view of the conceptions of rehabilitation which are gaining favour, at least as much should come from the latter as the former. The Committee thinks that in suitable cases the Standing Committee might usefully consider the administrative implications of recommendations or suggestions put forward by the Advisory Councils of the Ministry of Labour or the Health Departments. The list of departments represented on the Standing Committee (see Appendix K) seems to be admirably calculated to throw up (given a real interest on the part of the Ministries and departments concerned) the problems which ought to be brought to the attention of the Committee. The only alteration the Committee would suggest is the addition of the National Assistance Board.

CHAPTER XII. VOLUNTARY EFFORT

326. The Committee received representations from a large number of voluntary associations and heard evidence from those which are listed in Appendix A.

327. The views and evidence thus received covered a good deal of ground. Some of this naturally was concerned with the claims to special consideration of particular types of disabled persons, especially where the importance in numbers or the characteristics of the disability (often stated in general terms) was conceived to be underestimated or imperfectly recognised. A good deal and some of the most useful evidence was concerned with the administration of statutory services, for instance, the work of the disablement resettlement officers of the Ministry of Labour, the employment of the disabled under sheltered conditions, Remploy, and so forth. Representations were made, too, on the adequacy of existing services in various fields. All this has been taken into account by the Committee in framing its report and recommendations. Some of the witnesses went beyond these matters to advocate novel administrative machinery for dealing with the disabled, as, for instance, a national corporation for the disabled—an idea on which the Committee has made some observations in para. 314 above.

328. The objects which the Committee had in view in inviting representatives of voluntary associations to give oral evidence were fully achieved ; and it is desired to take this apportunity of expressing the Committee's appreciation of the time and the trouble taken by the officials and the members of the associations concerned.

329. The Committee did not think that it was within the ambit of its reference to make a survey of the voluntary associations in this field, or to analyse their future position and function in relation to the developing system of statutory services but it has certain views which it would like to express.

330. Organised voluntary effort for the care of the unfortunate, whether sick, disabled or in poverty, is a traditional feature of the British social scene. In the scale of its efforts, and in the standards which have been set, it may well be that voluntary service in this country is unique. Some of the agencies which are active today have a long history ; on the other hand, fresh groups and associations with humanitarian objects of this kind spring up every year and sometimes take root. The noblest example of all without doubt was the system of voluntary hospitals which has now been absorbed in the National Health Service. Humanitarian in origin, the hospitals, in conjunction with the universities, were the developing ground of medicine, surgery and the nursing services, and more recently of the new concepts and practice of the rehabilitation of the disabled. But many other voluntary organisations of widespread reputation spring readily to the mind.

331. In this field of effort there is a wide diversity of pattern and scale of organisation. While there is substantial tradition and continuity in many of the larger organisations, many are dependent upon the enthusiasm and leadership of a few individuals, and continuity—at any rate continuity of effectiveness—is less assured. While some are well-staffed and may depend in their field efforts largely upon paid officers, others depend mainly on the part-time efforts of voluntary helpers. A few of the more recent specialised associations are groups principally of disabled persons themselves. All, in one degree or another, draw on the work, as well as on the financial support, of private persons ; but the degree, as already stated, varies widely. All, again, depend on subscribers and on the produce of voluntary appeals, charitable bequests and the like ; and the gathering of funds by these means is often highly, indeed professionally, organised. But some societies also derive income from trusts, foundations and permanent endowments. The finance of voluntary effort for the disabled was touched upon in evidence and it is one of the aspects deserving of study. The Committee was told by more than one voluntary organisation that its work was hampered by lack of funds, and

the view was expressed that the total pool, so to speak, of voluntary contributions has not increased, although there are far more associations to draw from the pool. Others inferred that, with the growth of statutory services, the public no longer recognises the same need for voluntary contribution. This is a matter upon which the Committee has no information one way or the other. It is a matter for evidence. It is reasonable to suppose that, with the redistribution of disposable personal income which has taken place, the distribution of surplus income in our society has greatly changed and that the potential sources of an increase in charitable contributions have changed also.

332. The introduction of statutory services for the disabled as such is of comparatively recent date. Their establishment, and still more their development, will in certain basic respects transform the situation in which voluntary service for the disabled was active. As to the salutary nature of the social policy which they embody there can be no doubt ; and the long run effect will be not to make voluntary service needless, but to make it more valuable by inducing concentration on parts of the field which professionalised and institutional statutory provision by its nature cannot adequately touch, and perhaps by some changes of character. In what must be recgonised as being still a transitional period, the policy of the responsible departments and authorities has been not unduly to disturb the activities of the voluntary organisations which were already in the field, but to make use in the meantime of the assistance which they could afford. The plan has been to secure their co-operation on something like an agency basis, in which the voluntary association has been assisted in some cases with public funds more particularly funds directly administered by local authorities, such expenditure in turn having been reimbursed in varying proportions by the central government department responsible for the administration of the statutory provision. Collaboration of this kind has usually been coupled with the reservation of a power to the public authority concerned to ensure by inspection or otherwise that the services given were efficient and economic. This has not, from the public point of view, proved unsatisfactory ; and it has enabled the voluntary organisation, while availing itself of local and personal enthusiasm and exercising a wide discretion, both in the method of carrying out its work and in the treatment of those who come to it for assistance, to be relieved from some of the anxiety, which haunts the voluntary association, of making ends meet. At the same time it has benefited in many cases by help derived from the wider knowledge and experience of the public authorities concerned.

333. No drastic or early change in the pattern of these existing arrangements is proposed, provided always that the grant-paying authority has the right to inspect the service in the interests of efficiency and economy and exercises this right to a proper extent. Nevertheless, this type of co-operation, particularly where it tends to approach a sort of agency arrangement for the conduct of organised services of care and treatment, may not be in the long run a permanent feature, and this for two reasons. In the first place, comprehensiveness of service throughout the country is difficult to organise on the basis of voluntary effort. Experience shows that what can be provided in this way must be supplemented if a complete local service is to be maintained. Secondly, there is no advantage in trying to expand or to federate voluntary organisations on a nation-wide basis as a form of delegation of statutory duties. Something of their primary character as an outlet for the spirit of service of humane and socially minded individuals would be lost. The Committee feels, moreover, that a major statutory service of a professional or economic character could not be in fact economically run or conveniently

controlled on such a basis of delegation. Again, professional staff, such as trained social workers and the like, are, as the Committee has had ample opportunity to observe, in extremely short supply. The supply of almoners is one example. It would be uneconomic to increase the sundry demands on trained personnel of this sort who are essential for the organised statutory services.

334. On the other hand, voluntary effort has proved its value in the recognition and in the preliminary exploration of new fields. While modern statutory services, particularly the hospital services, undertake very remarkable experiments and give scope for the work of gifted individuals, it must be recognised that even in the matter of institutions, voluntary effort has thrown up some remarkable pioneer experiments. It must be hoped that scope may be left for such a contribution to continue.

335. It is possible to recognise in the existing picture a distinction and a contrast between voluntary organisations where there is a central executive body made up of interested persons responsible for the policy but served by salaried workers who carry out the day-to-day work of the organisation, and, on the other hand, the voluntary but organised service of private individuals —operating usually at a local level without pay, and generally on a part-time basis—actuated by an impulse to help disabled individuals. Both can be combined of course as, for example, in the ex-service organisations. But the point suggests a role of permanent importance for voluntary effort. Starting, as it was bound to do, from the foundation of the Tomlinson Report, the Committee recognised a great change in social attitude towards the disabled since the date of that Report. On the one hand the situation of the disabled person in the family circle, like that of the elderly, has become more difficult. This in part is a corollary of the concept of the Welfare State which has established itself, leading to a reliance on State provision; partly it arises from the new circumstances of family life—women's employment and the less compact texture of the family which has resulted from the greater financial independence of the younger members of the families. On the other hand, in various representations to the Committee, the demand for the individual care and attention of the disabled person has been put very high. The recommendations of this Report, especially in regard to the welfare services of local authorities, go some way to meet this demand. But, in its entirety, it is not possible fully to meet it by way of state provision. Both the cost and the demand for personnel will extend beyond what can be contemplated or would be tolerable. Nor is it right that this particular need should be met wholly in that way. It is the proper outlet for the compassion and the spirit of mutual help which are the saving grace of a society where so much store is set on material enjoyment and well-being. And it is in the mobilising of the voluntary personal effort, often involving self-sacrifice, of private persons, that voluntary service organisations can do their most fruitful work. There is no reason why such activities should not be carried on in very close association with statutory services, nor why they should not, under proper conditions, be aided from public funds. Indeed, co-operation with the welfare services of the local authorities under the powers recently given, and on the lines which the Committee has recommended in its report, should open a wide prospect for voluntary service by individuals co-operating together and an ideal field for their efforts.

336. It may be convenient, at this stage, briefly to summarize what has been said above upon the characteristics, limitations and possibilities of voluntary service, particularly as applied to the rehabilitation of the disabled. Voluntary service is an essential part of British social life. It has been outstanding as providing the means for developing new branches of social work

as they emerge. The patterns of organisation have always been greatly diverse, from one where the voluntary element was responsible for policy but its execution has been almost exclusively in the hands of paid and professional workers, to one which is a combining of the efforts in one place of a small number of voluntary workers. At present, many organisations find it difficult to obtain the funds they require. In some cases at the present time they rely mainly upon payments from public authorities for work undertaken on an agency basis, while the attitude of the public authorities has been to make such use as they can of voluntary effort on this agency basis without disturbing the organisations of the voluntary bodies. The Committee does not believe that the proper line of future development should be a simple but large increase in the use by public authorities of voluntary bodies as their agents. In the first place, the availability of voluntary effort throughout the country is far too patchy to allow this to be done nationally, and secondly, any expansion on a grand scale to overcome this defect would almost certainly destroy the voluntary spirit. In the Committee's opinion, therefore, the future of voluntary service lies in making the fullest use of its natural suitability for the exploration and development of new fields of work and the fact that the voluntary work equally naturally can supply that personal interest and care which is more difficult to provide through the ordinary machinery of the public welfare service.

337. What is here said, however, is not intended to anticipate the results of a general study of voluntary service to the disabled, but only to suggest a possible approach. There is here a very important group of problems to be studied and the Committee suggests that the time is ripe to set up a working party, or some similar body, which would be able to reach some conclusions about the nature of the contribution which might best be made by voluntary organisations in present circumstances.

CHAPTER XIII. FINANCIAL CONSIDERATIONS

338. In its terms of reference the Committee was asked to pay full regard to the need for the " utmost economy in the Government's financial contribution ". It therefore thought it desirable to attempt to express in financial terms the cost of rehabilitation, training and resettlement and perhaps to indicate the proportion of the national income devoted to these services. From this it hoped to be able to determine the extent to which the outlay gave a positive return or at least to point to particular directions in which savings were made. It has succeeded in neither endeavour, for what it believes to be very good reasons. So far as a straightforward estimation of the cost of the services is concerned it found that whilst certain activities could be isolated as being wholly or mainly devoted to rehabilitation, training and resettlement and accordingly their cost assessed, others were so involved with activities of various kinds not devoted to these services that it was impossible to draw any dividing lines between them. It found particular difficulty in arriving at the cost of the medical rehabilitation of the disabled because medical services are primarily preventive or curative, in that their main concern is to prevent the conditions which cause disability or, if the conditions arise, to cure them ; and the rehabilitation of those left with some residual disability is an inseparable part of the function. The medical services of rehabilitation would continue to be necessary largely on their present scale and with their present cost even if no problem of residual disability remained. Similarly, it has not been found possible to say what financial benefits result from the application of modern methods of rehabilitation as compared with earlier conceptions which were not narrowly

limited to the actual treatment of particular forms of sickness or injury. Appendix L contains a note (supported by illustrative case histories) prepared by a medical authority, on the economic aspects of rehabilitation and resettlement. This reveals some of the difficulties encountered in trying to compare costs and savings in the field covered by the Committee.

339. The Committee accordingly decided that enquiries into the total financial cost of rehabilitation were likely to prove fruitless. To some extent this led it to examine the worth of a purely financial expression of the value of the services and it appeared that it might well give a false picture and one leading to the supposition that if some direct financial saving could not be shown to accrue from a particular service that service was of relatively little value. In point of fact, the value in terms of enablement to take a full part in ordinary life or to contribute to it economically often bears no relation to the cash expenditure involved.

340. As the Committee's work proceeded and its conclusions began to form it became apparent that, apart from an important expansion in the welfare service mentioned below and in Chapter IV, it would be unnecessary to recommend developments which involved either great capital expenditure or great increases of staff. As the report shows, the Committee is in no doubt that it is by applying the best current methods more extensively that the existing measures for rehabilitation of the disabled would largely be improved. It found both that the legislation existed with ample powers to carry out all that was needed and that over the greater part of the field the services were already in being. Its recommendations centre upon the more effective use of these services and their interweaving so that full advantage can be taken of them. For example, patients who are able to leave hospital sooner than they do now relieve the pressure on beds and in consequence the hospital service is thereby made more effective economically. To the extent to which "planned convalescence" as recommended by the British Medical Association is applied the fewer will be the false starts and frustrations and the more complete and accelerated the restoration of patients to maximum living and working capacity. Here the savings are more obvious both financially and in terms of human well-being. The only major item of new expenditure which the Committee recommends is that there should be exchequer help for certain kinds of welfare services undertaken by local authorities. The annual cost of these might be in the neighbourhood of £6 million, and it does not consider that this is a large price to pay for the improvement to be gained thereby. (This is dealt with in Chapter IV.) In general, therefore, it considers that because it is not recommending anything which is costly or suggesting great changes in the way in which the services are now provided, precise figures or a detailed discussion of costs is of far less importance than if major changes were proposed.

341. Nonetheless, the Committee believes there may be a danger in assuming too readily that more effective services can be brought about solely, or even mainly, by increased expenditure, even where this is offset to some extent by the kind of savings just referred to. Experience has shown that some of the best work in the rehabilitation field has been done without expensive equipment and without elaborate organisation, relying far more on the capacity to inspire the disabled to help themselves and the intelligent adaptation of available materials and the personal enthusiasm of those engaged in it. At this stage the Committee would like to emphasise that in its view rehabilitation, to be most effective, is not to be regarded merely as the application of techniques and still less as a separate medical or other speciality, but above all as a constituent part of the thought and

action of all those who are concerned with the treatment of patients and the restoration of disabled persons to their utmost capacity.

342. Even if money for purposes of extending premises and equipment were made much more freely available there would still remain the difficulty of recruitment of trained staff, particularly for medical auxiliaries and social workers. Already the demand exceeds the supply in some branches of activity, and the Committee is aware of the competing demands of the educational, nursing and social services drawing on a limited supply of suitable candidates. Moreover, the Working Party on Social Workers under the chairmanship of Dr. Eileen Younghusband is studying the problem of the training of various kinds of social worker, so that this Committee would not wish to consider that problem. Nevertheless, attention has already been drawn (in Chapter XII) to the good work done by voluntary workers to aid the disabled and it would ask those concerned to consider more closely than perhaps has been the practice hitherto whether an extended use might be made of voluntary help for work which could conveniently be undertaken under the guidance of those who have been professionally trained.

Concluding Summary and Note of Recommendations

343. The Committee became increasingly aware during the conduct of this long inquiry of the change of focus in this inquiry from that of the Tomlinson Committee. On its terms of reference that Committee concentrated upon the reinstatement in employment of the disabled person ; the present Committee with its wider terms of reference has been able to consider him more broadly as a human being and a social unit. It has been better able to do this because of the development between 1943, the date of the Tomlinson Report, and 1953, the date of this Committee's appointment, of the organising ideas and the range of social services which constitute what is called the Welfare State. The difference of focus is reflected in this report.

344. A second impression is that, emanating from the Tomlinson Report and the Disabled Persons (Employment) Act which followed it, the facilities for enabling disabled persons to get suitable employment are comprehensive and well-established, needing little change or development. In recording this impression the Committee is aware that employment opportunities have been particularly favourable in recent years, but it believes that the services provided would be the most suitable whatever the economic circumstances.

345. A third impression is the evidence of a widening and deepening, over the same period, of the concept of rehabilitation on the medical side. This appeared in the oral evidence as well as in the admirable written submission of the British Medical Association. Contributing to this have been the clinical experience of a second war, the accelerating advances of medicine, surgery and mental health, developments in pharmacology, and besides all this, improvements in the processes of rehabilitation itself, based upon the pioneer work of many institutions. This is a major development even if it has still much way to make in practice.

346. A fourth impression is that of the completeness of the statutory provision which now exists for the services of the disabled. This is not to say that this complex of provisions is perfect, or that its full fruits are regularly reaped. But the foundations, whether legislative or in the way of financial provisions are there, and this has been thoroughly tested in the course of the Committee's inquiries.

347. The conclusions and recommendations of the Committee now bring together in one place an account of the services which a disabled person may

reasonably expect to receive under the Welfare State. The Committee moreover believes that it is now possible with some accuracy to determine the needs of each disabled person and thereby to secure the State against waste and abuse. This determination is provided by means of early and continuous assessment, based on advances in medical knowledge, in administration, and in the technique of social work, won in the last ten years.

348. The Committee, however, has felt from time to time that the very richness of provision of services within this field may lead to a passive acceptance of benefits with little active co-operation by the patient. This is wrong from every point of view, not least from that of the disabled person himself. The most active possible co-operation and the most complete determination to conquer his handicap is an essential to speedy recovery. This is well known to all workers in this field and has been demonstrated in countless histories of recovery of function and victory over disability, for which the word heroic is no idle compliment. The Committee has found itself both uplifted and humbled by encountering many such people, and wishes to record its view that in this field the spirit is demonstrably stronger than the flesh.

349. The Committee was impressed by the sympathy, understanding and desire to help the handicapped displayed by the personnel of the various services with whom they came into direct contact and is satisfied that the human standards in all these services are high and should be maintained.

350. The provision by the State of services to the disabled does not remove the need of voluntary service ; there remains a vast field for personal service in meeting individual human needs.

351. As the report observes, State provision for the disabled supervened upon a state of affairs where such provision was largely supplied by voluntary agencies, including the great system of voluntary hospitals. Both as regards the funds availabe or procurable, and as regards the ultilisation of voluntary personal services, a reorientation of the role of voluntary service (historically speaking) is due ; and this point has been made in the report.

352. The administrative complexity of the services available for the disabled is a point which has been made in evidence and is dealt with in the report. Upon this the Committee is satisfied that it is not possible to reduce the complexity very much for the system as a whole or in detail, and has been impressed by the degree in which, given the will to do so, all the agencies can work together at the point of contact with the disabled individual.

353. An improvement of knowledge among the general public, not simply of the range of services available for handicapped persons of all sorts and of the impressive achievements of these services in ameliorating their condition, but also of the ideas and aims of rehabilitation including industrial rehabilitation and resettlement, as they have now developed, would be of great public benefit. It would improve the climate of public and neighbourly opinion in which the disabled person has to meet and be helped to overcome his disabilities and it would provide a stimulating background for voluntary personal service in this field.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Chapter. I. Size of the Problem

No comprehensive figures are available or could perhaps be compiled of the number of handicapped persons throughout the country ; but such statistics and information as are available suggest that greater and more effective use could be made of existing provision in speeding up rehabilitation and return to work, and there may be room for some increase of provision. (Para. 16.)

Recommendation No. 1. The Committee recommends that inquiry be made to find out how many persons receiving sickness benefit for more than six months could be assisted in a return to work if suitable facilities for rehabilitation or resettlement were made available to them. (Para. 23.)

Chapter II. Hospital Services

The Committee directed its attention both to the use made of hospital resources generally and to the adequacy of the facilities specially concerned with the rehabilitation of the patient. In its view, the key to the full development of rehabilitation in the hospital service is the attitude of the hospital medical staff. (Paras. 39, 41.)

The Committee also found that although the principle of the rehabilitation approach to hospital treatment is accepted and, to some degree, applied, many consultants and general practitioners are still slow to consider the rehabilitation needs of their patients and doctors still need to be better informed upon the scope, nature and potentialities of rehabilitation. It accordingly trusts that all possible steps will be taken by medical schools and by the medical profession generally to bring home to doctors their responsibility for leadership in this field. (Para. 42.)

If in every physiotherapy department treatment were given which was intensive, planned for the individual patient and with a background of discipline, it might well be that attendances would be less prolonged and the need for staff thereby relieved. (Para. 43.)

Recent trends in occupational therapy towards treatment based more closely on activities akin to the daily work and experience of patients and the giving of advice and instruction on how to live with a disability should be encouraged. (Para. 44.)

There is a shortage of almoners and psychiatric social workers. They should not be employed on duties which can be discharged by others, and there may be room for the employment of less highly qualified assistants. (Para. 46.)

The Committee accepts the view that there is an unsatisfied need for planned convalescence of a more active nature to be provided either by daily attendance at clinics or by residence at a special centre. It found some difficulty in assessing the extent to which additional facilities of this kind are required. (Paras. 47 and 48.)

Recommendation No. 2. The Committee recommends that hospital boards should review and reorganise their present arrangements for the provision of physiotherapy so as to secure a purposeful graduated programme of activity designed to restore full function and to reorient the patient's outlook from that of an invalid to that of a responsible worker. The development of additional facilities, whether in day or residential centres, should take place as the need is revealed by hospital boards in their reorganisation and redeployment of existing resources in staff and in accommodation both for inpatients and outpatients at the convalescent stage. (Paras. 48 and 49.)

Assessment : Resettlement Clinics

If a patient is likely, on discharge, to be left with some residual disability, the hospital staff has a responsibility of assessing his probable capacity, recommending any further measures of rehabilitation or training and ensuring that at the earliest possible stage he is put in touch with those who will be able to help him. Assessment of capacity is essentially a medical

responsibility; liaison with other agencies is primarily the duty of the almoner or psychiatric social worker. (Paras. 51 and 52.)

Early and continuing assessment of a patient's future abilities is fundamental to satisfactory resettlement. In most cases, informal consultation between those concerned will suffice, but for the most difficult cases, a resettlement clinic is desirable. At present, such clinics exist in a comparatively small number of hospitals. For an effective service a resettlement clinic should be set up in each major hospital as a normal feature of its work, meeting regularly and dealing with patients from hospitals and those from other sources. (Paras. 53 and 55.)

Recommendation No. 3. The Committee recommends that regional hospital boards and boards of governors of teaching hospitals should review their present arrangements for resettlement clinics and should take steps to ensure that each major hospital sets up a clinic, meeting regularly to deal with cases referred by hospitals, general practitioners or others, in an area of convenient size surrounding the hospital. (Para. 57.)

Rehabilitation Committee of Regional Hospital Boards

Recommendation No. 4. The Committee recommends that regional hospital boards and boards of governors be invited to consider setting up a rehabilitation committee or sub-committee for the purpose of furthering recommendations in this report relative to the hospital service. (Para. 59.)

The General Practitioner

The general medical pracitioner should undertake fuller responsibility than he normally does at present for the rehabilitation and resettlement of his patients. However, there is among general practitioners a lack of sufficient knowledge both of the facilities available to them and of the use which can be made of them, so that there is a need for the further education of the profession in this respect. Various measures to benefit general practitioners could be taken—in particular:— (Para. 63.)

(*a*) visits to industrial rehabilitation units and vocational training centres;

(*b*) meetings with disablement resettlement officers;

(*c*) the inclusion of rehabilitation in the subjects studied in refresher courses provided under the National Health Service;

(*d*) provision of information in the handbook issued by the Ministry of Health;

(*e*) provision in each area of a short leaflet setting out the facilities, accommodation and staff available for patients with disabilities.

Recommendation No. 5. The Committee recommends that the Health and Education Departments, the Ministry of Labour and National Service, the Ministry of Pensions and National Insurance and the National Assistance Board should take all such steps as are necessary to provide the profession with the information it needs. (Para. 63.)

Regional Medical Service

A considerable proportion of the cases referred to regional medical officers might benefit from some form of rehabilitation.

Recommendation No. 6. The Committee recommends that whenever the regional medical officer is of opinion that a person referred to him would benefit from rehabilitation facilities of any kind known to him he should include a statement to that effect with such details as are necessary in his report. (Para. 64.)

Chapter III. Industrial Rehabilitation

The fifteen industrial rehabilitation units set up by the Ministry of Labour are now well established and are characterised by their realistic workshop atmosphere. The Committee is in no doubt that they perform a useful and necessary service. (Paras. 68 and 74.)

The fundamental principle underlying the relationship between hospital and industrial rehabilitation is that the rehabilitation process is a single process in which the emphasis at the beginning is on the medical aspects and at the end on the work aspects. (Para. 80.)

There is scope for development on both the hospital side and the industrial side and there is no fundamental obstacle to co-ordinated development.

> *Recommendation No.* 7. The Committee recommends that the larger share of what can be spared from the national resources for capital development for rehabilitation in the near future should be on the hospital side, but that some important existing industrial areas without industrial rehabilitation units should be supplied with them, particularly where this can be done relatively inexpensively, e.g. by the adaptation and equipment of existing premises. (Paras. 82 and 83.)

Industrial rehabilitation units should be ready to admit the rehabilitee at as early a stage as possible. There appears to be a misconception on the part of doctors that a patient must be certified as fit for work before he can be admitted. This is not the case. This misconception is clearly an impediment to the full use of the units, so that it is essential that it be removed as soon as possible. All that is required is that the unit doctor should regard the man as likely to be fit for work at the end of the rehabilitation course. (Para. 86.)

The part-time medical officer attached to an industrial rehabilitation unit may have to give more time in the future to the assessment and the treatment of those taking the course and to liaison with hospitals and general medical practitioners. (Para. 88.)

> *Recommendation No.* 8. The Committee recommends that the Ministry of Labour should provide for the additional medical sessions required for these purposes. (Para. 88.)

> *Recommendation No.* 9. The Committee also recommends that regional hospital boards should provide specialist services for those attending industrial rehabilitation units. This should be done wherever possible by arranging for a particular hospital to be linked with the industrial unit concerned. (Para. 89.)

> *Recommendation No.* 10. The Committee recommends that all new developments for industrial rehabilitation units or for hospital rehabilitation centres should be planned with the facilities and needs of the other service in mind. (Para. 90.)

Comprehensive Rehabilitation and Assessment Centres

The principle of the continuity of the rehabilitation process suggests the desirability of providing comprehensive facilities for hospital rehabilitation, industrial rehabilitation and assessment of capacity on the one site. Such comprehensive rehabilitation and assessment centres might be provided in areas where both hospital and industrial rehabilitation facilities are at present inadequate or require fuller co-ordination and where the remedy lies in new building rather than in the adaptation of existing premises.
(Paras. 91 and 92.)

Recommendation No. 11. The Committee recommends that a proportion of any additional resources set aside for rehabilitation services should be devoted to building two or three experimental centres of this kind. (Para. 93.)

Rehabilitation by Employers

Several large industrial firms have set up special rehabilitation workshops and it is hoped that other such firms will undertake similar ventures. Such workshops should have a link with the local hospital rehabilitation department so as to ensure continuity of treatment. (Para. 94.)

The Committee is not able to accept the suggestion that inducement payments should be offered to smaller firms. (Para. 97.)

Apart from such formal arrangements, employers can—and in many cases do—take steps so to modify the conditions or tempo of employment as to enable the disabled person on return to employment after illness or injury to accustom himself more gradually to industrial conditions. (Para. 98.)

Chapter IV. Welfare Services for the Disabled

Apart from the provision made for the blind, it is clear that in the field of local authority welfare services for the disabled only the fringes have been touched so far and there is no doubt that there is need for fuller and better provision and scope for considerable development. (Para. 106.)

The responsibilities of local authorities in the welfare field are:—

(*a*) to meet the social and occupational needs of those disabled who do not come within the employment field, and

(*b*) simultaneously to cater as far as may be required for the social needs of the disabled who are in the employment field.

The Committee believes that more would have been done by local authorities in the welfare field if it had not been the case that most of the services which they can provide attract no grant from central funds. (Para. 108.)

Recommendation No. 12. It therefore recommends that local authorities should be grant aided by the Exchequer in their expenditure on services provided by them under Section 29 of the National Assistance Act. Any such grant should be available without distinction between the type of disabled person or of services concerned, but the rate of grant would need to be calculated having regard to the extent to which services have already been provided in some fields. (Para. 124.)

In the development of the welfare field, more should be done to provide close co-operation between the local welfare authorities and the hospitals. For this purpose a suitable officer might be nominated by the local authority to visit the hospitals and attend case conferences designed to assess the welfare needs of particular patients. (Para. 110.)

There must be close co-operation between the several departments of a local authority or between local authorities on the one hand and the National Assistance Board, Ministry of Pensions and National Insurance, or other government departments on the other. (Para. 113.)

There must always be continuity of medical care, but particularly when a person enters the welfare field on discharge from hospital. The proper agency for attending to these medical needs is the general practitioner, who must be supplied promptly with all necessary information and be in personal contact with the offices of the welfare service. Hospitals have already been advised to send reports to general practitioners and the Medical Officer of

Health when the discharge of such a patient is imminent, but delays sometimes occur. (Para. 112.)

Recommendation No. 13. The Committee recommends that hospitals make it their invariable rule to send reports without delay. (Para. 112.)

Occupational and Social Centres

Local authorities are already beginning to provide centres for occupational and social purposes. These should include as one of their main objects the meeting of the needs of disabled persons outside the employment field. (Para. 115.)

Hostels

Two kinds of hostel appear to be needed: —

(i) short stay accommodation for persons leaving hospital and not yet fit for ordinary living accommodation, and

(ii) permanent homes for more dependent disabled.

It appears that a stage has now been reached where local authorities could, with advantage, devote some of their resources to providing short stay hostels. (Para. 119.)

Registration of the Handicapped by Local Authorities

The Committee does not think that registration should be compulsory on the disabled. Co-operation between the authorities concerned with the separate registers is essential and should be fostered, but interchange of information should not take place without the consent of the person concerned. (Para. 122.)

Chapter V. Appliances and Other Aids for the Disabled

The Committee reviewed the general question of appliances for the disabled and distinguished the following six groups :— (Para. 128.)

(1) Medical and surgical appliances and aids to mobility ;

(2) Aids to home nursing ;

(3) Personal aids for dressing, toilet and eating ;

(4) Aids to household activities ;

(5) Aids to industrial activities ;

(6) Aids to recreation.

No suggestions are made concerning the range of the articles in the first two groups. For groups (3), (4) and (6) the Committee recommends :— (Para. 128.)

(a) *Recommendation No.* 14, that local authorities should assist permanently disabled persons living at home by providing them with necessary personal aids. (Para. 131.)

(b) *Recommendation No.* 15, that structural adaptations in the home, now carried out by some local authorities, should be extended to all areas. (Para. 135.)

It is noted that group (5) may be the responsibility of the employer, in some cases these aids may be supplied by the Ministry of Labour and in the case of special attachments to artificial limbs, they may be provided under the National Health Service. The Committee hopes that the Ministry of Labour will continue to develop suitable "work aids" and to make their availability known. (Paras. 132 and 133.)

Use of Public Transport

Recommendation No. 16. The Committee recommends that the departments concerned should make a study of ways and means of helping the disabled in the use of public transport. (Para. 136.)

Chapter VI. Vocational Training

Since vocational training courses are of necessity intensive it is essential that the applicant has the appropriate education and aptitude for the particular course he chooses. The facilities provided for vocational training are as wide as is reasonably practicable. (Para. 144.)

The range of occupations for which organised classes at government training centres and technical institutions can be maintained is bound to be limited, mainly because of the small number of applicants coming forward. But the Committee is impressed by the flexibility of the present facilities which enable many different arrangements to be made to meet special situations, and by the number of skilled trades for which training has been provided. (Para. 145.)

Where numbers make it practicable to set up special training classes, skilled and experienced instructors are likely to provide systematic and intensive training more quickly and effectively than could most employers. (Para. 147.)

About 23 per cent. of those starting on courses of training do not complete them, but of these premature terminations the greater part take place very early on. On the other hand, no less than 95 per cent. of all disabled persons who complete the courses have been successfully placed in the occupations for which they have been trained. The Committee does not consider that this wastage rate is a matter for concern, and regards the results of the training scheme for the disabled as satisfactory. (Para. 146.)

Chapter VII. The Disabled Persons Register

Two main points were raised on the conditions precedent for registration, viz. being " substantially handicapped in obtaining or keeping employment ", and of having a " reasonable prospect of employment ".

The Committee considers that the present regulations with regard to the former are satisfactory, provided they are properly interpreted. (Para. 158.)

As regards the latter the problem concerns persons who, owing to their physical or mental condition, are very doubtfully employable or who are shown by experience not to retain employment if accepted. It is not practicable or desirable to remove these from the existing register, or to set up a separate section of those considered to fall within this category. Nevertheless, at the time of renewal of registration a stricter interpretation of the " reasonable prospect of employment " registration condition should be applied. (Para. 160.)

The Committee does not accept the suggestion that disability in relation to employability can be expressed in arithmetical (percentage) terms. (Para. 159.)

The Committee believes that minor improvements can be made in the administration of the regulations and accordingly recommends as follows:—

Recommendation No. 17. Since assessment for acceptability for work will often turn on medical evidence, specialist medical opinion should be available to reinforce or advise disablement resettlement officers and Disablement Advisory Committee Panels. (Para. 160.)

Recommendation No. 18. The regulations governing registration should be amended so as to enable patients of hospitals or institutions who are able to engage in employment although still retained as patients in the hospital to be registered as disabled persons. (Para. 163.)

Recommendation No. 19. The qualifying period for registration should be that the disability should be expected to last for a minimum period of one year in place of the present period of six months. (Para. 161.)

Recommendation No. 20. A maximum period for registration should remain but it might be longer than the present period of five years. (Para. 162.)

Recommendation No. 21. The regulations dealing with non-British subjects should be revised so as to provide that the benefits of registration should be extended to all those who are in this country on a work permit without reference to any residential qualification, provided that the alien satisfies the normal eligibility conditions. (Para. 164.)

Recommendation No. 22. The regulations should be amended to make provision for the voluntary removal of a disabled person's name from the register on receipt of a written request from him. (Para. 165.)

Quota Scheme

The quota scheme has been of assistance in widening the opportunities of employment and in giving a measure of security, but in present circumstances its main value lies in its educational importance in demonstrating the wide range of occupations which can be undertaken successfully by disabled persons. (Para. 169.)

The present standard percentage appears satisfactory and adequate arrangements are provided for a revision whenever necessary. (Para. 171.)

Differential quotas are not recommended because of the administrative difficulties which they would create and the anomalies and inconsistencies which they would introduce. (Para. 171.)

The definition of employer for quota purposes is considered equitable as it seems reasonable that large firms operating small branch establishments should be subject to a quota covering all their staff. (Para. 172.)

The weighting of disabilities for quota purposes is impracticable because of the difficulty of any precise measurement of disability in terms of employment handicap. (Para. 173.)

There should be no change in the present provision that registered disabled persons whose registration has lapsed should be allowed to count towards their employer's quota for so long as they remain with the same employer. (Para. 174.)

Designated Employment Scheme

At the present time, under the designated employment scheme, two occupations are designated:—

(i) car park attendant;

(ii) passenger electric lift attendant.

Recommendation No. 23. The Committee recommends that these two occupations should continue to be designated but that if at any time there should be need for more pressure on employers to employ disabled persons, such pressure should be applied through the quota scheme rather than by any extension of designated employment. (Paras. 177 and 178.)

The Placing of the Disabled in Employment

The Ministry of Labour's policy on the resettlement of the disabled is based on the view expressed in the Tomlinson Committee's Report that the only satisfactory form of resettlement for a disabled person is employment which he can take and keep on his merits as a worker in normal competition with his fellows. The Committee agrees with this view. (Para. 182.)

The role of the disablement resettlement officer is primarily that of an employment officer and his main concern is with the placing of disabled persons in suitable employment. (Para. 183.)

The present method of appointment to the post of disablement resettlement officer is right. It is not necessary that disablement resettlement officers should be recruited from the ranks of social workers. (Para. 186.)

The placing of the disabled in employment is part of the Ministry of Labour's normal placement service and it would be undesirable for it to be a specialised and vocational service within the Ministry. (Para. 187).

The committee considers that improvements can be made in certain directions and therefore recommends as follows: —

(a) *Recommendation No.* 24. The Ministry of Labour should take steps to secure that its methods of selection are such as to ensure that in all disablement resettlement officer appointments the fullest consideration should be given to the officer's suitability and inclination for this work. (Para. 189.)

(b) *Recommendation No.* 25. The present three to four day initial training course should be very considerably extended in time so as to make it far more comprehensive. It should include such a period of training on the job under the supervision of a group disablement resettlement officer or experienced local disablement resettlement officer as will thoroughly equip the newly appointed officer for the work he is to do. (Para. 190.)

(c) *Recommendation No.* 26. Disablement resettlement officers should deal with all the disabled persons within a specified area whatever their disabilities and they should continue to co-operate with voluntary organisations, hospitals, local authorities and doctors in that area. (Para. 191.)

Superannuation Schemes

There is no reason why the operation of superannuation schemes need prejudice the employment of the disabled, and so far as the Civil Service and service with local authorities is concerned, there seems to be no ground for supposing that superannuation conditions have any influence on the appointment of a disabled person. The Committee was informed that for private firms it should always be possible to make provision for the disabled in superannuation schemes but it sometimes happens that disabled persons are precluded from employment because of such schemes. (Paras. 193 to 195.)

Subsidies to Employers

A subsidy to an employer in respect of the employment of the disabled might mean that a disability, instead of being regarded as a handicap to be overcome in the right job, would tend to be looked upon as qualifying for a special financial consideration. There would also be severe administrative difficulties in working such a scheme. The Committee fully agrees, therefore, with the Tomlinson Committee's view that subsidies to employers in these circumstances are undesirable in principle and impracticable. (Para. 197.)

Chapter VIII. Sheltered Employment

Sheltered employment is only second best to competitive employment, so that as many persons as possible should be encouraged to graduate from sheltered workshops to work under ordinary conditions. If sheltered employment is to be a success, the beneficiaries should be those who are willing to undertake the work provided and able to make a significant contribution to production. All sheltered workshops, whether for the sighted or the blind, should be regarded as places of employment with as high as possible a rate of individual productivity. (Paras. 199 and 200.)

When provision is to be made to occupy those who are capable only of a modicum of effort and industry, it should be provided under the welfare provisions of the National Assistance Act and not through the employment service. (Para. 201.)

Provision of Sheltered Employment by Local Authorities

The Committee thinks it important to draw a clear distinction between disabled persons in the employment field and those who are not, and having in mind the employment functions of the Ministry of Labour it recommends as follows :— (Para. 201.)

(a) *Recommendation No.* 27. The powers of local authorities to provide sheltered employment, whether in workshops or in the home, whether for the blind or the sighted and whether under the National Assistance Act or the National Health Service Act should be transferred to the Disabled Persons (Employment) Act in so far as these powers relate to persons who can be regarded as being covered by Section 15 of that Act and are, therefore, able to engage in remunerative employment. (Paras. 201 and 207.)

(b) *Recommendation No.* 28. The provision of work as defined in Section 29 of the National Assistance Act, in respect of the blind, should continue to be a duty imposed upon local authorities, but should be carried out under the powers to be given to them by the Disabled Persons (Employment) Act. (Para. 205.)

The Committee does not regard the present system of augmentation of the wages of blind persons as entirely satisfactory and would prefer to have a payment system which depended to some extent on incentive payment and had more regard to the value of the work done. (Para. 200.)

Sheltered Workshops run by Voluntary Organisations

The Committee commends the valuable work undertaken by the voluntary organisations to provide for the training and employment of severely disabled persons and considers that the Ministry of Labour should continue to assist them financially provided that the persons they employ satisfy the conditions mentioned, viz. (i) that they should be willing to undertake the work provided and able to make a significant contribution to production ; (ii) that the workshops are efficiently managed and (iii) open to inspection by the Ministry of Labour. (Para. 208.)

Remploy Limited

Remploy is operating a social service for the disabled but one which seeks to demonstrate that given suitable conditions of work, even the badly disabled person may find a place again in industry and feel that he is making some effective contribution to the country's production. It is unreasonable to expect this social service to operate without a loss, particularly during an inflationary period. Moreover, the Committee does not think that the present loss is, in all the circumstances, excessive. The Committee has, however, some suggestions to make. They are :— (Para. 213.)

(*a*) Remploy should review its practice in regard to the selection of their workers to see whether better standards of assessment of aptitude and capacity can be applied both before and during employment. (Para. 211.)

(*b*) Everything possible should be done to encourage the movement from Remploy factories to open employment. (Para. 213.)

There are at least 6,000 persons for whom employment in a Remploy factory appears to be the only likely opportunity of employment; this number can reasonably be expected to be a minimum. (Para. 214.)

Recommendation No. 29. The Committee recommends that the present scheme of providing sheltered employment through Remploy factories should continue. (Para. 215.)

Government Contracts

In view of the importance of a full and steady flow of work, the Committee urges that both government departments and local authorities should give sheltered workshops the fullest possible opportunity to tender for contracts in the wide range of goods which workshops can now supply. At the same time, the priority suppliers should continue to compete in the ordinary commercial market. (Paras. 221 and 222.)

Chapter IX. Homeworking Schemes

Homeworking schemes can have two distinct ends :—

(*a*) the provision of diversionary occupation (occupational homework); and

(*b*) the means to enable a living to be earned (remunerative home employment). (Para. 224.)

There is need for more occupational homework for the homebound which, while providing some financial return, is chiefly beneficial for the mental and physical stimulus which results from engaging in a useful occupation. It is particularly desirable to improve the opportunities for disabled homeworkers to make outside social contacts. (Para. 228.)

There is not any great untapped source of remunerative work waiting to be exploited, so that it is unlikely that more than a limited number of homebound disabled persons will be able to earn a reasonable living from home employment. Furthermore, there is a risk that in making strenuous attempts to command a living wage, the disabled person may well work long hours in conditions which are deleterious to health. The Committee has the following recommendations to make: (Para. 231.)

(a) *Recommendation No.* 30. While existing schemes of remunerative home employment should be continued and, if possible, developed much more consideration should be given to the alternative of bringing disabled persons to their work. (Para. 233.)

(b) *Recommendation No.* 31. Local authorities should be encouraged to exercise their powers under Section 29 of the National Assistance Act to provide occupational homework as widely as possible. (Para. 228.)

The Committee considers that no change should be made in the present requirements that :

(*a*) earnings in excess of £1 a week are taken into account in considering the amount of national assistance payable although the National Assistance Board might consider the exercise of discretion in certain cases; (Para. 239.)

(*b*) full national insurance contribution is payable if earnings exceed £1 a week; (Para. 236.)

(*c*) when earnings exceed £1 a week, sickness benefit is affected; (Para. 237.)

(*d*) earnings should not exceed £52 0s. 0d. a year, net, as a test of unemployability for the purpose of the special allowance granted to war pensioners. (Para. 238.)

The Committee considers that a careful watch should be kept by the departments concerned to ensure that the figures are in due relation to the conditions obtaining at the time and that they provide sufficient elasticity.
(Para. 238.)

Chapter X. The Young Disabled

It is generally recognised and accepted that every boy and girl should be given the fullest opportunity of educational facilities during their school life and of training to fit them for employment. There is no evidence to suggest that the existing arrangements are not generally adequate to ensure that all handicapped children are made known to the authorities. Provided the responsible authorities continue to exercise constant vigilance to ensure that the existing machinery is used to its full extent, compulsory registration of disabled children would not be more effective than the present system. The school medical services provide adequate facilities for medical assessment in all state provided schools and the National Health Service provides the necessary medical treatment. But education of the child in hospital presents a difficult problem and the decision whether it can be given education in a hospital is essentially a matter of medical opinion. The Committee considers that special attention should be given to this problem and, therefore, makes the following recommendations: (Paras. 244, 246 and 247.)

(a) *Recommendation No.* 32. Local education authorities should ensure that hospital authorities know what facilities can be provided for children in hospitals; (Para. 247.)

(b) *Recommendation No.* 33. Hospital authorities should arrange to bring to the notice of local education authorities the particulars of children in hospitals for whom educational arrangements should be made; (Para. 247.)

(c) *Recommendation No.* 34. Local education authorities should make periodical inquiries of those hospitals likely to have young patients requiring education so as to ensure that the education of long-term child patients is not overlooked. (Para. 247.)

The Committee wishes to emphasise the need for particular care and attention in the initial careers advice and placing of the disabled before they leave school. For disabled young persons, placing alone is not sufficient. The youth employment officer should undertake a systematic and meticulous follow-up of all placings of disabled young persons so that as far as possible he can ensure that they are in suitable employment and do not drift to unsuitable work. The aim in view is likely to be achieved more satisfactorily if the attention of schools, parents and others concerned is drawn to the importance of giving adequate vocational preparation to disabled young persons rather than by compulsory use of the Youth Employment Service. The normal careers advice and placing service for school leavers is available for children leaving special schools so that it is unnecessary and undesirable to create new machinery for special schools alone. It does not appear wise generally to introduce a service dealing with disabled young people alone. It is important that the youth employment officer should have close contact with the welfare department of the local authority, so that young persons in need of welfare services can easily be referred for necessary assistance.
(Paras. 251, 252, 253, and 254.)

There is a gap between the age—fifteen years—at which children may leave ordinary schools and the minimum age—sixteen years—at which vocational training and industrial rehabilitation under the Disabled Persons (Employment) Act become available. (There is no gap in the case of pupils leaving special schools where attendance is compulsory up to sixteen years of age.)
(Para. 257.)

Recommendation No. 35. The Committee recommends that, as this gap is undesirable, the school leaving age should be made the minimum age for the provision of vocational training and industrial rehabilitation under the Disabled Persons (Employment) Act. (Para. 257.)

Disabled Ex-Service Men and Women

The normal provision for the rehabilitation, training and resettlement of disabled persons, coupled with the generous help given by voluntary societies or organisations and the war pensioners' welfare service, ensures that the particular needs of ex-service men are kept well to the fore. Although the Disabled Persons (Employment) Act is more comprehensive in its scope than the King's National Roll, the latter scheme should not be terminated so long as it provides some assistance for the pensioners within the employment field. (Paras. 263 and 259.)

The Blind

Statutory provision for the assistance of the blind has existed for some time, as also has well organised voluntary help. The Committee, therefore, does not wish to make any general comment, but has certain observations to make on specific points which arise from the conclusions of the Working Party on the Employment of Blind Persons, which reported in 1951. The Working Party considered that newly-blinded persons should have the opportunity of attending residential establishments so that they could become adjusted to blindness, learn how to adapt themselves to new social and economic circumstances and be assessed for the kind of subsequent employment most suitable for them. The Committee agrees that, although the present services of local authorities play a valuable part, many newly-blinded persons, particularly younger people, would benefit by the more comprehensive facilities which can be provided at a residential establishment. In these establishments, two forms of rehabilitation are available. They are distinguished as social and industrial rehabilitation. The Ministry of Labour already makes a contribution towards the cost of industrial rehabilitation. Local authorities may make a contribution towards the cost of maintaining a blind person at such a centre. (Paras. 269 and 270.)

Recommendation No. 36. The Committee recommends that expenditure incurred by local authorities upon social rehabilitation in this way should rank for the grant recommended in paragraph 124. (Para. 270.)

The Committee considers that, under the existing arrangements, the provision of a placement service specially for the blind, has over the country as a whole led to a patch-work of administration, resulting in a service for the blind inferior to that available for other classes of the disabled. (Para. 273.)

Recommendation No. 37. The Committee recommends that the Ministry of Labour should assume full responsibility for ensuring that the placement of the blind is put on a satisfactory footing and should itself normally provide a placing service, thus relieving local authorities of the responsibility at present assigned to them. Local authorities and voluntary organisations at present carrying out the work satisfactorily should continue to do so if they wish, at any rate for the time being. (Para. 273.)

The Tuberculous

It is important that the tuberculous patient should be given some occupation within his capacity, which will engage his attention and help in his recovery. It is the joint responsibility of the hospital and education authorities to meet the needs of adult patients. Although in some hospitals provision is made through local authorities or otherwise to give patients an occupation, this practice does not at present appear to be as well known or as widespread as it should be. (Para. 277.)

Recommendation No. 38. The Committee recommends that hospital authorities should approach the education authority with a view to introducing, whenever possible, education facilities of a kind suitable for tuberculous patients. (Para. 277.)

As recovery continues, every opportunity should be taken of extending the range of activities, including those requiring physical effort, and when the patient is capable of working for three or four hours a day a much more ambitious programme of activity should be attempted.

Recommendation No. 39. The Committee recommends that, in conjunction with chest clinics, the Ministry of Labour should inquire from time to time to ascertain what facilities might be introduced for the part-time training of tuberculous patients. (Para. 278.)

Many tuberculous patients returning to their former employment do not encounter any special difficulties, but for those who are not able to do so or to find work of a similar kind, the prospects of early employment are much reduced. There is a grave risk, therefore, that some tuberculous persons will find their way into work unsuitable for them, running risks to themselves and becoming a danger to their fellow workers. Close co-operation between chest physicians and disablement resettlement officers is, accordingly, necessary to assess the capacity of the patient and then to consider what suitable employment can be found. Village settlements continue to do useful work, particularly in training for outside employment persons still in the infectious stage of tuberculosis. Nevertheless, by no means all tuberculous persons, whether suitable for such settlements or not, are able or willing to go to them so that there is a need for the provision of hostels for those in training or employment who cannot live at home. (Paras. 279, 281 and 282.)

Recommendation No. 40. The Committee recommends that more hostels of this kind for tuberculous persons whose home circumstances are unfavourable or for whom suitable employment cannot be found near their homes, should be established where they are found to be necessary. (Para. 282.)

It was suggested that there is a tendency for the tuberculous person to remain without work and in receipt of sickness benefit or other payments longer than was really necessary. (Para. 283.)

Recommendation No. 41. The Committee recommends that, on the basis of registrations at chest clinics, inquiries should be made to ascertain how far there are appreciable numbers of ex-tuberculous patients remaining unemployed who, given the proper measures of rehabilitation might once again resume work. (Para. 283.)

Paraplegics

Much progress has been made in the treatment and the resettlement of paraplegics, but it is particularly necessary for them carefully to be followed up after they leave hospital. Some, on discharge from hospital, need special attention and accommodation which cannot be provided in ordinary hostels or at home, or have no home to which they can go. These need special accommodation, of which that provided at the Duchess of Gloucester House is a good and successful example. Certain voluntary organisations have also successfully established special settlements for paraplegics. Nevertheless, ideally, paraplegics should, wherever possible, live at home and go out to work, preferably in ordinary competitive industry, but, if necessary, in a sheltered workshop. For this purpose, living conditions may need to be specially adapted. (Paras. 284, 286 and 287.)

Recommendation No. 42. The Committee recommends that local authorities and others concerned should give special attention to the needs of paraplegics by doing all they can, through adaptations or otherwise, to provide suitable living accommodation. (Para. 287.)

The Mentally Handicapped

Patients who have recovered from psychosis or neurosis, and high grade mental defective patients who have been socially trained and are employable, need the same kind of help as others in resettlement, after care and welfare services but there is a special need for close co-operation between the different services. Convalescent patients whose recovery is not as complete as those mentioned above need expert rehabilitation to help them in obtaining work. (Para. 292.)

Recommendation No. 43. The Committee accordingly recommends that hospitals and the Ministry of Labour should consider the possibility of a wider use of arrangements whereby suitable patients before discharge from hospital are given courses at industrial rehabilitation units. (Para. 293.)

This group may also, on discharge from hospital, need accommodation in hostels whilst they are undergoing rehabilitation or training or on first entering employment, but the extent of the demand is by no means clear. (Para. 294.)

Recommendation No. 44. The Committee recommends that local authorities should be encouraged to experiment in the provision of hostels to provide accommodation for convalescent patients discharged from mental hospitals to accommodate them whilst they undergo industrial rehabilitation or training or on first entering employment. (Para. 295.)

Neurotic or mildly psychotic patients and medium grade mental defectives or other defectives with residual instability who are employable but need to live under psychiatric supervision and care, are not fit for discharge from hospital. However, they may better receive the care they need in separate annexes convenient to their work rather than in the main hospital itself. (Paras. 291 and 296.)

Recommendation No. 45. The Committee recommends that in developing the mental and mental defective hospital services hospital authorities should pay particular attention to the possibility of providing accommodation in annexes for patients with a residual instability who are employable. (Para. 296.)

Deteriorated mental patients and low grade mental defectives need to remain as inpatients in mental or mental deficiency hospitals, but some of them are capable of training and occupation in hospital workshops. Simple factory work might be provided for them by arrangement with local industry. (Paras. 291 and 297.)

Recommendation No. 46. The Committee recommends that hospital authorities should consider the possibility of providing simple factory work for deteriorated mental patients and low grade mental defectives by arrangement with local industry. (Para. 297.)

Spastics

Special measures over and above those ordinarily available to disabled persons are not generally necessary or even desirable to cater for the needs of spastics. Early and accurate assessment is the key to their satisfactory education and settlement. It is particularly important that the family doctor and the health visitor impress on the parents the need for such assessment and be ready fully to inform parents of the many ways in which help can be given to handicapped children. (Paras. 300 and 301.)

Epileptics

Recent advances in medical knowledge of epilepsy offer much greater hope that epilepsy can be controlled, so that the objective in the rehabilitation of epileptics must be to enable more of them to live a normal life in the community. There must, however, be some proportion who will need special provision either for short or longer periods. Their needs require close co-operation between the different authorities responsible for the several services. While in these respects no special comment on the problems of the epileptics is called for, there is one problem which is more prominent—the difficulty which the epileptic encounters in obtaining and retaining employment. It is essential that the capacity and the disability of the epileptic should be fully assessed, that his condition has been controlled and information frankly exchanged between the doctor in charge of the case and the disablement resettlement officer. It is also necessary for the public to be enlightened upon the variations in the degree of the disability and that there is a high proportion of epileptics who are only lightly handicapped.

(Paras. 303, 304 and 305.)

Deaf

Deaf or deaf and dumb children need special treatment and their disability gives rise to a problem both of medical treatment and education. Accurate assessment, auditory training, often the provision of a hearing aid at the earliest possible moment are of the greatest importance.

The rehabilitation of older persons suffering from defects of hearing does not call for special comment because deafness in itself is not normally a barrier to employment. (Para. 307.)

Chapter XI. Administrative Arrangements

The present statutory powers and arrangements for administration are sufficient to provide all the facilities that are needed for the satisfactory resettlement of the disabled person. The Committee does not consider that to superimpose upon the existing organisation, a new body not itself directly involved in any phase of the work of rehabilitation would be of advantage, or that a single government department should take responsibility nor that there should be a national corporation for the disabled. On the other hand, to secure the most efficient operation of these services, sensitive contact and willing co-operation is necessary between the various agencies and departments concerned, both at the centre and at the local level. Similarly, local coherence in the service can best be achieved by regular informal meetings between the local workers. To bring this about some particular initiative is needed which may come either from an individual, a voluntary association, a government department or a local authority. In the last resort, the local authority should take it upon itself to give the encouragement and the opportunity for such meetings. (Paras. 317, 311–314 and 321.)

The question of overlapping and duplication might well be kept under regular review by the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons. The Committee also hopes that the Standing Committee may produce further surveys on rehabilitation at regular intervals on the lines of their reports already issued. The Standing Committee might also usefully consider the administrative implications of recommendations or suggestions put forward by the Advisory Councils mentioned below. The composition of the Standing Committee is admirably calculated to fit them for their duties, but it would be enhanced by the addition of representatives of the National Assistance Board. (Para. 325.)

To provide a forum for the expression of well-informed opinion, there are the Advisory Councils to the Minister of Health, the Secretary of State for

Scotland and the Minister of Labour, and the local advisory committees. These obviously perform a most useful and worthwhile service and it is most desirable that they should continue. (Para. 323.)

Chapter XII. Voluntary Effort

Voluntary service is an essential part of British social life and has been outstanding as providing the means for developing new branches of social work, but at present many organisations find it difficult to obtain the funds they require. Some of them rely upon payments from public authorities. A large increase in the use by public authorities of voluntary bodies as their agents does not appear to be a proper line of future development. Because there are many problems involved, the Committee suggests that the time is ripe for setting up a working party or some similar body which would be able to reach some conclusions about the nature of the contribution which might be made by voluntary organisations in present circumstances. (Paras. 336 and 337.)

The future of voluntary organisation lies in making the fullest use of the natural suitability of voluntary service for exploration and development in new fields of work and the fact that voluntary work naturally can supply a personal interest and care which is more difficult to provide through the ordinary machinery of the public welfare service. (Para. 336.)

Chapter XIII. Financial Considerations

An estimate of the total financial cost of rehabilitation (to the Exchequer and other public funds) is not readily obtainable as the greater part would require to be dissected out from the general costs of the services concerned in it ; the figures of specialised services which are concerned only or mainly with the disabled might give a misleading idea of the total financial burden. This appears the less important as, apart from the expansion in the welfare service of local authorities mentioned in Chapter IV, the Committee has not found it necessary to recommend developments involving either great capital expenditure or great increases in staff. It is, moreover, dangerous to assume that more effective services can be brought about solely or even mainly, by increased expenditure, because some of the best work in the rehabilitation field has been done by relying upon the capacity to inspire the disabled to help themselves and the intelligent adaptation of available materials. (Paras. 338, 339, 340 and 341.)

The Committee wishes to record its deep appreciation of the help received during the three and a half years of its work from the Secretaries, Mr. G. C. H. Slater of the Ministry of Labour and National Service, and Mr. T. C. L. Nicole of the Ministry of Health. Their wide knowledge of the subject, their personal concern for the care of the disabled, their ability in preparing and presenting the large volume of written evidence which has been considered, their skill in drafting and their unfailing patience and judgment have been of a wholly exceptional order, and have made the Committee's task much less arduous and intricate than the Committee might have had reason to expect. The Committee wishes to record its thanks also to their Assistant, Mr. T. R. Jenkins of the Ministry of Labour and

National Service, who has not only been responsible for making all the routine arrangements necessary for the smooth functioning of the Committee but has given great assistance throughout in recording discussions and in the drafting and revising of Committee papers and of the Report itself.

(Signed) PIERCY (*Chairman*).
JOHN A. BARRACLOUGH.
F. BRAY.
CLAUDE FRANKAU.
ANTHONY GREENWOOD.
FLORENCE HANCOCK.
J. HOPE-WALLACE.
J. H. F. LUDGATE.
C. GAULTER MAGEE.
J. E. PATER.
ALEX. B. TAYLOR.
P. H. ST. J. WILSON.

G. C. SLATER
TOM NICOLE } *Joint Secretaries.*

24th September, 1956.

APPENDICES

APPENDIX A

ALPHABETICAL LIST OF ORGANISATIONS AND INDIVIDUALS SUBMITTING WRITTEN EVIDENCE

* Denotes those organisations or individuals invited to give oral evidence in support of their written memoranda

Allen, Miss M.
*Arthur, Mr. John.
*Association of County Councils in Scotland.
Association of Hospital Management Committees.
Association of Hospital and Welfare Administrators.
*Association of Municipal Corporations.
*Association of Occupational Therapists.
Association of Social Workers.
Association of Supervisory Staffs Executives and Technicians.
Atkins, Mr. R. W.
Austin Motors Ltd.

Bell, Mr. A. H.
Benjamin, Mr. Richard.
Berbeck, Mr. D.
Boot Trades Association Ltd.
Boy Scouts Association.
*British Association of the Hard of Hearing.
*British Association of Physical Medicine.
*British Council for Rehabilitation.
*British Council for the Welfare of Spastics.
*British Employers Confederation.
*British Epilepsy Association.
British Hotels and Restaurants Association.
British Legion (Preston Hall).
British Legion, Scotland.
*British Limbless Ex-Service Men's Association (B.L.E.S.M.A.).
*British Medical Association.
British Red Cross Society.
*British Red Cross Society—Scottish Branch.
*British Rheumatic Association.
British Student Tuberculosis Foundation.
Brown, Dr. Arnold (Cheshire County Medical Officer).
Burgin, Mr. R.

Carter, Mr. M. A.
*Central Council for Care of Cripples.
Central Council for District Nursing in London.
*Chartered Society of Physiotherapy.
Church Army.
Claro, Mr. F. J.
Collis, Dr. Eirene.
*County Councils Association.
Creamer, Miss B. B.

Davey, Mr. Harry.
Deaf Children's Society.
Diabetic Association.
Diaper, Mr. W. H.
Dickson, Mr. J.
Doctor Barnardo's Homes.
Druce, Mr. W. J.
Dunham, Dr. Wm.

East Lancashire Tuberculosis Colony (Barrowmore Industries).
Empire Rheumatism Council.
Evans, Mr. E. W.
Ex-Services Welfare Society.

*Forces Help Society and Lord Roberts Workshops.
Freeman, Miss R.

Gardiner, Mr. J.
Gott, Mr. A.
Guide Dogs for the Blind Association.

Haley, Miss C. E.
Hargraves, Mr. J. M.
Harris, Dr. R.
Harris, Mr. R.
Harrison, Mr. J.
Haverson, Mr. R. F.
Helping Hand Association, Oxford.
Howes, Mr. L.

Industrial Advisory Council for Scottish Institutions for the Blind.
Industrial Welfare Society.
*Infantile Paralysis Fellowship.
*Institute of Almoners.
*Institute of Hospital Administrators.
Institute of Personnel Management.
International Haemophilia Society.
Invalid Tricycle Association.

Joint Industrial Advisory Council for Scottish Institutions for the Blind.
*Joint Tuberculosis Council.
*Jones, Dr. Maxwell.

Kingsbury, Mr. I.

*London County Council.

MacFeat, Dr. George.
Macdonald, Miss E. M.
Mair, Dr. Alexander.
Marsh, Dr. Kenneth.
Marsh, Mr. K.
Marris, Miss M. S.
McCracken, Dr.
Medical Officers at industrial rehabilitation units.
Meiklejohn, Dr. A.
Merritt, Mr. W.
Middlesex Education Committee.
Morton, Lt.-Col. A. D. (Wessex Weavers).

*National Association for Mental Health and the Association of Psychiatric Social Workers.
*National Association for Mental Health and the Mental Health Workers Association.
*National Association for the Paralysed.
*National Association for the Prevention of Tuberculosis.
*National Association of Workshops for the Blind Incorporated.
National Car Parks Ltd.
National Coal Board and National Union of Mine-workers and Coal Industry Social Welfare Organisation.

National Council of Social Service.
National Federation of the Blind.
*National Institute for the Deaf.
*National League of the Blind.
National Society for Epileptics.
National Spastics Society.
Nickson, Mr. H.
Nottinghamshire County Council (Sherwood Village Settlement).

*Order of St. John of Jerusalem and British Red Cross Society—Joint Committee—
(1) Emergency Help and After Care Department.
(2) Hospital and Medical Services Department.

Papworth Village Settlement (Dr. R. R. Trail).
Parkinson, Mr. A.
Perkins, Mr. J. E.
Perry, Mr. J. E.
Peters, Mr. D. F.
*Peto, Sir Geoffrey.
Pierce, Mr. P. W.
Pinder, Mrs. J.
Portland Training College for the Disabled.

*Queen Elizabeth's Training College for the Disabled.

*Remploy Ltd.
*Remploy Ltd. (Homeworking).
Ritherdon, Mr. K. G.
Royal Association in Aid of Deaf and Dumb.
Royal College of Nursing.
*Royal College of Physicians of Edinburgh.
*Royal College of Surgeons, Edinburgh.
*Royal College of Surgeons of England.
*Royal Faculty of Physicians and Surgeons of Glasgow.
Royal London Society for the Blind.
*Royal Medico-Psychological Association.
*Royal National Institute for the Blind.
*Rodger, Dr. Alec.
Russell, Mr. D. J.
Rutherden, Mr. K. G.

Salmon, Miss F. A.
Scott, Mr. W.
Scott-Rimington, Mr. G.
Scottish Association for Mental Health.
*Scottish Epilepsy Association.
Scottish Orthopaedic Council.
Scottish National Federation for Welfare of the Blind.
Shanks, Mr. R. W.
Sherma, Mr. D. H.
Shaftesbury Society.
Sharp, Mrs. M.
Seston, Lt.-Col. C. F.
*Society of Medical Officers of Health.
Standing Conference of Voluntary Organisations.
St. Loyes College.
Smith, Mr. L. A.
Spence, Mr. L.
Stevens, Mr. A. V.
Stevenson, Mr. H. J.

Teeling, Mr. P. W.
Thompson, Mr. I.
*Trades Union Congress.

Union of Shop, Distributive and Allied Workers.

Vandyk, Mr. N. D.
*Vauxhall Motors Ltd.

Warrington, Mr. K. G.
Wells, Mr. W. R.
Weltman, Mr. L. L.
West, Mr. E. C.
Whellock, Mr. C. S.
Whitfield, Mr. W. R.
Whyte, Miss F. M.
Woods, Mr. R. S.

APPENDIX B

PERSONS REGISTERED UNDER THE DISABLED PERSONS (EMPLOYMENT) ACT AT 16TH APRIL, 1956

In the following Table, the persons on the Register at 16th April, 1956, are classified according to the disablements which made them eligible for registration at the time of their applications. These disablements are not necessarily the only ones which these persons have and they may not now constitute the primary handicap to employment.

Nature of Disablement	1914–1918 War-disabled Pensioners	Other Ex-Service Persons	Non Ex-Service	Total
Amputations	18,708	19,406	26,889	65,003
Arthritis and rheumatism	1,449	17,086	14,476	33,011
Congenital malformations... ...	37	736	13,682	14,455
Diseases of digestive system ...	2,116	31,528	16,580	50,224
Diseases of heart, etc.	5,425	24,521	25,187	55,133
Diseases of lungs	5,754	29,079	24,848	59,681
Ear defects	3,451	10,464	22,037	35,952
Eye defects	6,819	18,206	29,980	55,005
Injuries of head, face, neck, thorax, abdomen, pelvis and trunk ...	16,419	13,302	7,862	37,583
Injuries and diseases of lower limb	24,362	36,990	39,531	100,883
Injuries and diseases of upper limb	25,260	24,572	23,356	73,188
Injuries and diseases of spine ...	1,077	13,662	15,787	30,526
Nervous and mental disorders ...	6,145	25,264	42,855	74,264
Tuberculosis...	2,942	30,988	37,019	70,949
Other diseases and disabilities ...	3,097	17,301	22,024	42,422
Total	123,061	313,105	362,113	798,279

APPENDIX C

SUMMARY TABLES PREPARED FROM MINISTRY OF PENSIONS AND NATIONAL INSURANCE "DIGEST OF STATISTICS ANALYSING CERTIFICATES OF INCAPACITY—1953/54"

TABLE I

Claimants incapacitated owing to sickness on 5th June, 1954, analysed by age groups

Age	Men	Women	Total
	(Thousands)	(Thousands)	(Thousands)
15–19	15·8	26·9	42·7
20–24	24·4	31·6	56·0
25–29	32·1	22·9	55·0
30–34	39·1	19·2	58·3
35–39	36·9	17·1	54·0
40–44	48·3	25·3	73·6
45–49	59·4	33·5	92·9
50–54	73·1	42·3	115·4
55–59	89·4	47·3	136·7
60–64	106·1	2·9	109·0
65 and over	15·5	—	15·5
TOTALS (about)	540	269	809

TABLE II

Claimants incapacitated owing to sickness on 5th June, 1954, analysed by duration of spell of sickness

	Men	Women	Total
	(Thousands)	(Thousands)	(Thousands)
Up to 1 month	164·1	72·2	236·3
1–3 months	84·1	36·6	120·7
3–6 months	51·9	21·8	73·7
6 months to 1 year	47·7	20·4	68·1
1–2 years	53·0	23·3	76·3
2–3 years	29·0	13·7	42·7
3–4 years	22·3	11·1	33·4
4–5 years	18·9	9·8	28·7
Over 5 years	69·2	59·9	129·1
TOTALS (about)	540	269	809

APPENDIX C—*continued*

TABLE III

Claimants incapacitated owing to sickness on 5th June, 1954, analysed by duration of spell at that date and age of claimant at 31st December, 1953

	Total*	Duration of spell at 5th June, 1954		
		Up to 6 months	Over 6 months and up to 2 years	Over 2 years
		(Thousands)	(Thousands)	(Thousands)
Men:				
All ages†	540 (66)	300	101	139
15–44	197 (33)	136	29	32
45–54	133 (16)	76	23	34
55–64	195 (15)	77	46	72
Married Women:				
All ages†	110 (6)	54	17	39
15–44	54 (3)	34	6	14
45–54	36 (2)	15	6	15
55–59	20 (1)	5	4	10
Other Women:				
All ages†	158 (24)	76	27	55
15–44	89 (15)	53	14	21
45–54	40 (6)	14	7	19
55–59	28 (3)	7	5	15
Men and Women†	809 (95)	430	145	234

* Figures in brackets show the number included in the figure who are known to have been in hospital.

† Includes about 15,000 men over age 65 and 3,000 women over age 60 who had not yet taken their retirement pensions.

The statistics relate to men and women who were away from work on a given day (5th June, 1954) and who were on that day certified to be incapable of work. The figures in question are, if anything, an under-statement of the position since they exclude:—

(*a*) Nearly all persons whose sickness lasted less than 4 days;
(*b*) Married women who when at work chose not to be insured for sickness benefit—amounting to rather more than half of all working married women;
(*c*) Most men aged 65 or over and most women aged 60 or over;
(*d*) Persons who become sick before getting established in the employment field.

As will be seen, however, they cover almost the entire field that is of interest to the Committee and as such are a valuable source of information bearing upon the size of the problem.

Table I shows that, although the numbers by groups are larger for the elderly (the 50–65 age groups) who are less likely to benefit from rehabilitation facilities, sickness generally is spread over all age groups.

Table II. As will be seen from this table, out of the total of 809,000 persons included in it, over 370,000 had been away from work owing to sickness for more than 6 months. Nearly 130,000 of these had been away from work for over 5 years and no doubt these are mainly chronic sick who are unlikely to benefit from rehabilitation facilities. The most likely field for rehabilitation is among those who had been away from work for between 6 months and 2 years, a total of some 144,000.

Table III correlates the figures contained in Tables I and II showing the duration of sickness by age groups. In particular, it shows the composition of the group of 85,000 men and women mentioned in paragraph 22 between the ages of 15 and 54 who had been incapacitated for work for periods of between 6 months and 2 years.

APPENDIX D

STATISTICAL INFORMATION ON THE AVAILABILITY OF FACILITIES FOR REHABILITATION IN HOSPITALS IN THE NATIONAL HEALTH SERVICE

1. The following Tables are designed to give a general indication of the availability and the distribution of the principal facilities (other than medical or nursing services) which contribute, in hospital, to the rehabilitation of hospital patients. They therefore show the numbers of hospitals at which the following services were provided—physiotherapy, occupational therapy, remedial gymnastics, social work (almoners).

2. The hospitals have been divided into types according to the nature of the work carried on in them.

England and Wales

3. Taking each service separately, it will be seen from Table I that *physiotherapy* is provided at 73 per cent. of acute, 87 per cent. of mainly acute and 93 per cent. of orthopaedic hospitals.

4. *Occupational therapy* is less widespread, but it is more widely provided than Table I would suggest since—particularly in mental and mental deficiency hospitals—craft instructors of various kinds are also employed, and in many hospitals occupational therapy of a diversional character is organised by voluntary workers.

5. *Remedial gymnasts* again are much more generally available than the distribution of remedial gymnasts shown in Table I would appear to indicate. The introduction of the remedial gymnast is a recent development, and group exercises or remedial gymnastics are frequently provided at other hospitals by the physiotherapist. The remedial gymnast tends to be more commonly met in the north than in the south, no doubt because the only training school at present in existence is at Wakefield.

6. *The social service* of almoners tends at present to be comparatively scanty outside the large general hospitals. It must be borne in mind that at mental and mental deficiency hospitals much of this work is done by the psychiatric social worker. The distribution over the country is also uneven, being much more adequate in the teaching hospitals and in and around London than in the rest of the country. The deficiency is recognised, but it is not one that can be met quickly or easily. Suitable candidates for the profession are not numerous, and there is considerable competition from other fields of social work, e.g., psychiatric social work, child care, probation work, etc. Assistance to recruitment is being given by a special scheme of grants to suitable candidates administered by the Ministry of Health.

Scotland

7. As Table II indicates, the highest range of availability of *Physiotherapy* is found in the general hospital groups. By contrast the convalescent hospitals have a lower range.

8. In *Occupational Therapy* the highest concentration of services is found in the mental and mental deficiency and tuberculosis hospitals.

9. *Remedial Gymnasts* form a very small group in the Scottish hospitals, a total of only 10 being employed. Much remedial gymnastic work, however, is carried out by physiotherapists.

10. While the *Almoner Service* is found in most types of hospitals other than isolation and mental and mental deficiency hospitals, the main centres are in the larger general hospitals. The total number of almoners is small.

APPENDIX D—*continued*

TABLE I

ENGLAND AND WALES—ALL HOSPITALS AS AT 31ST DECEMBER, 1955

	Acute	Mainly Acute	Partly Acute	Mainly Long Stay	Long Stay	Chronic	Pre-Convalescent	Convalescent	Rehabilitation	Isolation	Maternity	Mental and M.D.	Orthopaedic	T.B.	T.B. and Isolation	Children	E.N.T., Eye, Miscellaneous, etc.
Total Number of Hospitals as at 31st December, 1955	733	114	40	57	60	275	71	65	13	69	256	323	42	202	65	48	219
In-patients Discharges Totals	493,873	147,460	40,096	16,317	8,392	12,050	11,483	8,199	1,789	3,422	49,328	23,292	8,410	11,010	9,959	27,061	67,328
New Out-patients Totals	989,687	185,519	34,921	9,613	2,008	1,277	668	16	94	—	46,506	7,433	11,762	8,826	3,865	39,706	220,858
Physiotherapists	538	99	31	32	29	100	24	8	10	4	53	29	39	68	14	32	95
Occupational Therapists	181	70	29	31	26	76	10	4	7	—	—	157	24	135	28	6	51
Remedial Gymnasts ...	78	17	7	—	1	2	3	—	10	—	—	8	6	1	—	—	9
Almoners	268	79	27	19	11	56	6	1	2	—	18	6	17	58	9	24	63

APPENDIX D—*continued*

TABLE II

SCOTLAND—ALL HOSPITALS

AVAILABILITY OF SERVICES AT 31ST MARCH, 1956

	General	Mainly General	General (Mainly Chronic Sick)	General (Chronic Sick)	General (Sick Children)	Convalescent	Isolation	Tuberculosis	Isolation and Tuberculosis	Maternity	Mental and Mental Deficiency	Miscellaneous
Total number of Hospitals	122	10	9	39	9	19	4	37	33	54	52	14
Physiotherapists	73	7	6	6	4	2	—	5	5	6	5	2
Occupational Therapists	12	4	3	1	1	2	—	9	8	—	30	1
Remedial Gymnasts	5	—	1	—	—	1	—	—	—	—	4	—
Almoners ...	27	3	3	—	3	1	—	1	2	4	1	3

APPENDIX E

COURSES OF TRAINING PROVIDED UNDER THE VOCATIONAL TRAINING SCHEMES DURING THE FIRST HALF OF 1956

Building, Ancillary and Civil Engineering Trades

Bricklaying
Carpentry
Contractors Plant Mechanic
Painting
Paving and Flag Dressing
Plastering
Plumbing
Wood Machining

Engineering Trades

Draughtsmanship
Fitting (Basic, General, and Aircraft Detail)
Instrument Making
Machine Operating: (Miscellaneous, turning, capstan operating, milling, grinding)
Capstan operating, inspection (Blind)
Welding: (Electric, Oxy-acetylene)

Agriculture and Horticulture

Administered by Ministry of Agriculture, Fisheries and Food in England and Wales and by Department of Agriculture in Scotland as part of the Government Vocational Training arrangements

Other Trades

Agricultural Machinery Repair Fitter, Blacksmith/Welder
Agricultural Machinery Repair Fitting
Art Marble Worker
Basket Making
Boat Building
Boot and Shoe Making (Handsewn including surgical footwear)
Boot and Shoe Repairing
Chair Caning
Cooking—Canteen, Hotel
Clerical—Builders Clerk
Clerical and Commercial
Confectionery—Wrapping (Blind)
Comptometer and Calculating Machine Operating
Copy Typing
Dressmaking—Home Worker
Dressmaking and Women's Light Clothing:
(*a*) Machinists,
(*b*) Hand-sewers
Electrical Contracting
Electrical—Light Electrical Servicing
Embroidery
Emidicta Typing
Furniture—Cabinet Making
Gardening
Glassware, scientific, lampblown (Bench hand)
Hairdressing (Men)
Handyman
Home Teacher for the Blind
Hosiery
Instrument Mechanic
Leather (Heavy, Light Made-up Goods)

Monumental Mason—letter cutting
Motor Repairing
Nursery Nursing
Ophthalmic Optical Industry
Piano Manufacture—Bench hands
Piano tuning and repair
Photography
Physiotherapy (Blind)
Pottery
Printing and Allied Trades
Radio and Television Servicing
Remedial Gymnasts
Retail Distribution (General)
Saddlery and Harness Making
Scale Making
Shirt Cutter
Shorthand and Typewriting
Sign-writing: Ticket and Poster Writing
Silk Screen Printing and Stencil Cutting
Silversmiths, Jewellery and Allied Industries
Spray Painting
Steno-typing
Surgical Appliance Making (Leather)
Surgical Appliance Making (Metal)
Storekeeping
Tailoring (Ready-made and Wholesale Bespoke)
Tailoring (Retail Bespoke)
Taxi Driving
Telephone Switchboard Operating
Thatching
Typewriter Mechanic
Vehicle Building (Coach Body Building) and Finishing
Vehicle Building (Coach Painting)
Watch and Clock Repairing
Weaving (Moquette)

APPENDIX F

WEEKLY RATES OF MAINTENANCE ALLOWANCES

Age and position as regards dependants (1)	Designation of Rates (2)	Local (3) Man s. d.	Local (3) Woman s. d.	Boarder (4) Man s. d.	Boarder (4) Woman s. d.	Boarder (4)	Trainee attending Residential Centre (5) Man s. d.	Trainee attending Residential Centre (5) Woman s. d.	Trainee attending Residential Centre (5)
I. *Trainees aged 20 and over:*									
Without wife or dependant	A	90 0	73 0	60 0	48 6	Plus for men and women, a further allowance towards the cost of lodging and part board, i.e., all meals except the mid-day meal from Monday to Saturday inclusive.	50 0	38 6	Plus free lodging and full board.
Maintaining dependent child or children under 16	B	98 0	81 0	68 0	56 6		58 0	46 6	
With wife or maintaining adult dependant(s)	C	110 0	93 0	80 0	68 6		70 0	58 6	
With wife (or maintaining adult dependant(s)) and maintaining dependent child or children under 16...	D	118 0	101 0	88 0	76 6		78 0	66 6	
II. *Trainees under age 20:*									
Without wife or dependants:									
Aged 19		72 0	64 6	47 0	42 0		37 0	32 0	
Aged 18		60 0	55 0	40 0	36 0		30 0	26 0	
Aged 17		50 0	47 0	35 0	34 0		25 0	24 0	
Aged 16		46 0	44 0	32 0	32 0		22 0	22 0	
With wife or maintaining dependant(s) ...	Married men under 20 years of age, and single men aged 19 and women aged 19, who maintain dependants, are paid allowances at rates B, C or D as appropriate. Trainees aged 18 and under who maintain adult dependants, or dependent children, receive rates higher by 20s. and 8s. a week respectively, than those for trainees of the same age without dependants.								

NOTE: If training is received at a non-residential establishment in which mid-day meals are provided, 10s. a week (8s. 4d. if training is given on 5 days a week) towards the cost will be deducted from the rates of allowances quoted in cols. (3) and (4) above.

ADDITIONAL PAYMENTS WHICH MAY BE MADE

1. A trainee who has to leave home for training and continues to keep up his home and be the main support of his dependants there, may qualify for a weekly payment of 24s. 6d.—called a " living-away-from-home " allowance.

2. Whether a trainee lives at home or in lodgings reasonable daily travelling expenses to and from the training establishment will be paid where necessary.

APPENDIX G

Date	Number of Registered Disabled Persons Unemployed shown Quarterly from January, 1953								
	Capable of Ordinary Employment —Section I			Capable of Employment only under Sheltered Conditions—Section II			Total		
(1)	Males (2)	Females (3)	Total (4)	Males (5)	Females (6)	Total (7)	Males (8)	Females (9)	Total (10)
1953									
19th January	48,981	7,228	56,209	6,525	628	7,153	55,506	7,856	63,362
20th April	45,194	6,574	51,768	6,072	635	6,707	51,266	7,029	58,475
20th July	38,714	5,697	44,411	5,693	629	6,322	44,407	6,326	50,733
19th October	40,690	6,206	46,896	5,311	564	5,875	46,001	6,770	52,771
1954									
18th January	43,189	6,476	49,665	5,069	523	5,592	48,258	6,999	55,257
20th April	39,781	6,194	45,975	4,521	517	5,038	44,302	6,711	51,013
19th July	31,882	4,941	36,823	4,201	430	4,631	36,083	5,371	41,454
18th October	33,781	5,417	39,198	4,081	462	4,543	37,862	5,879	43,741
1955									
17th January	36,019	5,603	41,622	4,122	453	4,575	40,141	6,056	46,197
18th April	31,712	5,251	36,963	3,875	411	4,286	35,587	5,662	41,249
18th July	26,572	4,514	31,086	3,531	404	3,935	30,103	4,918	35,021
17th October	29,342	5,099	34,441	3,485	391	3,876	32,827	5,490	38,317
1956									
16th January	32,438	5,466	37,904	3,523	427	3,950	35,961	5,893	41,854
16th April	31,492	5,475	36,967	3,391	439	3,830	34,883	5,914	40,797

APPENDIX H

PENSION SCHEMES IN PRIVATE FIRMS AND THEIR EFFECT ON THE EMPLOYMENT OF DISABLED PERSONS

The Committee is informed that for private firms there are, broadly, two types of pension schemes, those undertaken by one of the life offices and those financed by private fund administered by trustees.

Where the pension scheme provides solely for retirement benefit, medical examination of new entrants to the scheme is not as a rule enforced, as in such schemes it is the individuals who live to a ripe old age rather than those who die early that cause the biggest drain on the pension funds.

Some pension schemes involve a substantial life assurance benefit and in such cases it is understood that it may be necessary to exclude members suffering from disabilities which apparently reduce the expectation of life. It is said that the main class of pension scheme in which a substantial life assurance element exists is the type operated through endowment assurance policies granted by a life assurance office. In those cases, where a pension scheme is operated by deferred annuity contracts entered into with a life assurance office or through a domestic fund on a similar basis, these considerations do not arise as the benefit on death consists generally of the return of the employers' and employees' contributions accumulated at a relatively low rate of interest and no financial loss to the pension fund normally occurs on the death of a member.

Some pension schemes, however, operated in conjunction with an obligatory widows' and orphans' fund, thus providing in effect substantial life assurance benefits, and in such cases medical examination of new entrants may be enforced.

In order to qualify for tax concessions, all types of superannuation scheme must be approved by the Inland Revenue and in this connection a scheme may not be so framed that it empowers the employer to exclude arbitrarily an employee who is within an eligible category. The Inland Revenue would not object to a scheme being voluntary, nor to regulations designed to exclude one or more categories of individuals, and schemes sometimes include such arrangements. The Committee understands that the life offices have expressed their willingness to examine sympathetically any requests for a " contracting out " clause or the inclusion for modified benefits of persons who would not be insurable at ordinary rates of premium for life assurance policies. So far as funded schemes are concerned, the remedy is largely in the hands of the employer to arrange his scheme as he wishes subject to the approval of the Inland Revenue. The Association of Superannuation and Pension Funds has expressed its willingness to advise employers on the various ways in which modification can be introduced in order to provide greater flexibility.

APPENDIX I

ANALYSIS OF STATUTORY SERVICES AVAILABLE TO DISABLED PERSONS IN GREAT BRITAIN

Service	By whom service provided	Responsible Government Department	Legislative provision
EDUCATIONAL SERVICE			
Facilities for handicapped children and young persons in ordinary and special schools, at hospitals and at home.	Local Education Authorities (usually direct but sometimes through voluntary organisations).	Ministry of Education. Scottish Education Department.	Education Act, 1944. Education (Scotland) Act, 1946.
MEDICAL AND ALLIED SERVICES			
NATIONAL HEALTH SERVICE			
(1) Hospital and Specialist services.	Regional Hospital Boards: Boards of Governors of Teaching Hospitals.	Ministry of Health. Department of Health for Scotland.	National Health Service Act, 1946. National Health Service (Scotland) Act, 1947.
(2) General medical and dental services, pharmaceutical service and supplementary ophthalmic service.	Executive Councils.		
HEALTH SERVICES PROVIDED BY LOCAL HEALTH AUTHORITIES			
Home nursing, health visiting, domestic help and ambulance services.	Local Health Authorities.		
EMPLOYMENT SERVICES			
(1) For handicapped young persons.	Youth Employment Service (through Local Education Authorities or Ministry of Labour Local Offices).	Central Youth Employment Executive of Ministry of Labour.	Employment and Training Act, 1948. Disabled Persons (Employment) Act, 1944.
(2) Registration of disabled persons, operation of quota and designated employment schemes, placing in ordinary and sheltered employment.	Local Offices of Ministry of Labour.	Ministry of Labour.	Disabled Persons (Employment) Act, 1944.
(3) Industrial Rehabilitation.	Industrial Rehabilitation Units (Ministry of Labour); Rehabilitation Centres for the blind (voluntary organisations).	Ministry of Labour.	Disabled Persons (Employment) Act, 1944.

APPENDIX I—*continued*

Service	By whom service provided	Responsible Government Department	Legislative provision
(4) Vocational Training.	Ministry of Labour. Government Training Centres or through Local Education Authorities and voluntary organisations. Directly by employers.	Ministry of Labour.	Disabled Persons (Employment) Act, 1944.
(5) Sheltered Employment.	Remploy Ltd.	Ministry of Labour.	Disabled Persons (Employment) Act, 1944.
	Voluntary organisations. Local Authorities.	Health Departments and Ministry of Labour.	National Assistance Act, 1948.
OTHER SERVICES			
Welfare of the substantially and permanently handicapped, including accommodation.	Local Welfare Authorities directly or through voluntary organisations.	Health Departments.	National Assistance Act, 1948.
War Pensions, welfare of war pensioners.	Ministry of Pensions and National Insurance (Local Offices).	Ministry of Pensions and National Insurance.	Royal Warrant (War Pensions).
National Insurance Benefits, Industrial Injury Benefit.	Ministry of Pensions and National Insurance (Local Offices).	Ministry of Pensions and National Insurance.	National Insurance Acts, 1946–1953. National Insurance (Industrial Injury) Acts, 1946–1953.
National Assistance Grants.	National Assistance Board (Local Offices).	National Assistance Board.	National Assistance Act, 1948.

APPENDIX J

LIST OF MEMBERS OF CENTRAL ADVISORY COMMITTEES (AUGUST, 1956)

(1) Ministry of Health

MEMBERSHIP OF ADVISORY COUNCIL FOR THE WELFARE OF HANDICAPPED PERSONS

Name	*Nominating Body*
Chairman: Edward Evans, Esq., C.B.E., M.P.	National Institute for the Deaf.
N. D. Bosworth-Smith, Esq., C.B. ...	—
Alderman Dr. Kathleen Chambers, C.B.E., LL.D., J.P.	North Regional Association for the Blind.
Alderman Mrs. Olive G. Deer	London County Council.
J. Rhaiadr Jones, Esq.	Central Council for the Care of Cripples.
K. P. McDougall, Esq.	The British Deaf and Dumb Association.
Councillor E. E. Mole, J.P.	Association of Municipal Corporations.
Councillor Miss May O' Conor, O.B.E....	County Councils Association.
R. G. Richards, Esq., O.B.E.	County Councils Association.
Godfrey Robinson, Esq., C.B.E., M.C. ...	National Institute for the Blind.
Alderman R. G. Robinson, J.P.	Welsh Board of Health.
R. B. Semple, Esq., M.D., D.P.H. ...	Society of Medical Officers of Health.
T. H. Smith, Esq.	The National League of the Blind.
Alderman Mrs. G. Tebbutt, J.P. ...	Association of Municipal Corporations.
J. A. L. Vaughan Jones, Esq., C.B.E., M.B., Ch.B., J.P.	British Medical Association.
H. Willard, Esq.	The British Association of the Hard of Hearing.

(2) Department of Health for Scotland

MEMBERSHIP OF SCOTTISH ADVISORY COUNCIL ON WELFARE OF HANDICAPPED PERSONS

The Hon. Lord Stevenson, O.B.E., Q.C. (*Chairman*)
Chas. H. W. G. Anderson, Esq., T.D., B.Sc., F.R.S.E., Headmaster, Royal Blind School, Edinburgh.
W. Veitch Anderson, Esq., L.R.C.P., F.R.C.S. (Ed.), L.R.F.P.S. (Glas.), Surgeon, Edinburgh.
James Cormack, Esq., M.B.E., Superintendent, Edinburgh and South-East Scotland Society for the Blind.
J. J. R. Duthie, Esq., M.B., Ch.B., F.R.C.P. (Ed.), Senior Lecturer, Medical Department of Edinburgh University and Consulting Physician to South-Eastern Regional Hospital Board.
Rev. J. A. Fisher, Convener, Kirkcudbright County Council.
D. Kennedy Fraser, Esq., M.A., B.Sc., F.R.S.E., Psychologist and Master of Method, Jordanhill College, Glasgow.
James Hutcheon, Esq., J.P., Town Clerk, Dumfries.
Mrs. Douglas Johnston, M.B.E., Director, Glasgow Branch of British Red Cross Society.
D. L. McIntosh, Esq., M.B.E., Late Superintendent, Glasgow School for the Deaf.
Mrs. A. W. Mackenzie, Hon. Secretary, Scottish Orthopaedic Council (now defunct)
Duncan R. Matheson, Esq., LL.B., F.S.A.A., Chairman, Welfare Committee, Edinburgh Corporation.
Lt.-Col. J. M. Miller, M.C., Convener, Berwick County Council.
John Robertson, Esq., Welfare Services Officer, Stirling County Council.
William Taylor, Esq., C.B., Former Under-Secretary, Ministry of Labour and National Service, Member, Board of Management for Aberdeen General Hospitals.
Rev. W. H. Wood, Hon. Secretary, Scottish Association for the Deaf.

APPENDIX J—*continued*

(3) Ministry of Labour and National Service

MEMBERSHIP OF THE NATIONAL ADVISORY COUNCIL ON THE EMPLOYMENT OF THE DISABLED

Chairman

Sir Harold Wiles, K.B.E., C.B.

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A. B. Badger, Esq., M.A., Ph.D.... ...	Nationalised Industries.
Brig. J. A. Barraclough, C.M.G., D.S.O., O.B.E., M.C.	British Employers' Confederation.
I. R. Broad, Esq., M.B.E....	The Association of British Chambers of Commerce.
E. DeAth, Esq., C.B.E., D.C.M.... ...	British Employers' Confederation.

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Lieutenant-Colonel C. S. Woodward, O.B.E., D.L., J.P.

APPENDIX K

DEPARTMENTS REPRESENTED ON THE STANDING COMMITTEE ON THE REHABILITATION AND RESETTLEMENT OF DISABLED PERSONS AS AT AUGUST, 1956

Ministry of Education.
Ministry of Health.
Ministry of Labour and National Service.
Ministry of Pensions and National Insurance.
Scottish Education Department.
Department of Health for Scotland.
Ministry of Labour and National Insurance, Northern Ireland.

APPENDIX L

NOTE PREPARED BY A MEDICAL AUTHORITY ON THE ECONOMIC ASPECTS OF REHABILITATION AND RESETTLEMENT WITH FOUR CASE HISTORIES PUT FORWARD BY A LONDON TEACHING HOSPITAL

The essential problem in the study of the economics of rehabilitation and resettlement is to compare the cost of providing these services with the resulting saving in expenditure on maintaining the disabled and the gain in production in terms of wages. Unfortunately, so many variable factors have to be taken into consideration that it is very difficult to produce a true balance sheet. The purpose of this paper is to illustrate some of these difficulties by means of case histories from the records of a general hospital.

It is possible to cost certain services used exclusively for rehabilitation such as medical rehabilitation centres, industrial rehabilitation units, vocational training and the disablement resettlement services at the employment exchanges. However, these specialised services are required mainly for the more severely disabled patients and account for only a proportion of the total expenditure on rehabilitation. Moreover, as will be seen, the necessity to spend large sums on rehabilitation or none at all often depends on the efficiency of medical advice and therapeutic methods.

Rehabilitation is an integral part, but only a part, of the complex medical and social procedures involved in the prevention and management of disability. It is often difficult to decide if a particular service to a patient constitutes an aspect of rehabilitation or some other form of medical or social care. For instance, throughout the treatment of illness doctors have to pay attention both to definitive treatment and rehabilitation. The proportion of time which should be devoted to rehabilitation varies in different disorders and it is virtually impossible to estimate the extent to which the costly item of medical salaries should be ascribed to rehabilitation.

Much the same applies to the medical auxiliary and social services. For example, physiotherapy is used in rehabilitation to assist the restoration of function, but it is also used for the relief of pain, to accelerate the resolution of inflammation and in the definitive treatment of certain disorders in a manner analagous to the use of drugs. It might be thought that at least the time spent on remedial exercises might be properly charged to rehabilitation but, in fact, considerable use is made of them, with or without drugs, to prevent certain complications of illness. For instance, exercises to improve the circulation and anti-coagulant drugs are used to prevent venous thrombosis in the legs after certain operations. It might be argued that by preventing complications in this way remedial exercises are promoting rehabilitation but, if this is accepted, the use of certain drugs must also be charged to rehabilitation.

Similar difficulties arise throughout the medical and social services. In practice it is often very difficult to decide upon the dividing line, and therefore to allocate cost, between definitive treatment, social welfare and rehabilitation as shown by the following case histories.

Case 1

A male aged forty-seven. At the age of twenty-one, whilst serving as a quartermaster in the Merchant Navy, he contracted encephalitis lethargica followed by a persistent tremor of the right arm and leg. He was discharged from the Merchant Navy and failed to find any alternative employment. He attended the neurological department of the hospital on a number of occasions between 1941 and 1947 but made little or no improvement. In 1952 a new drug was tried which controlled the tremor so well that nine months later he was recommended for rehabilitation. After four months in the hospital rehabilitation department, two months in an industrial rehabilitation unit and six months' training in clerical work he was placed in employment as a clerk and he is still in the same job three years later.

Whilst the disability appears to be stable at the present time and the man now good for many years' work, further deterioration is liable to occur in this disorder or the drug may cease to be effective at any time in the near or remote future.

It is possible to calculate the sickness benefit paid to this man over twenty-four years as well as the cost of his medical and industrial rehabilitation. However, a realistic balance sheet in this case would have to take other factors into account. For instance, the long period of neurological supervision, a proportion of the cost of developing the new drug, hypothetical income in the Merchant Navy, depending upon his rate of promotion, and income tax which might have been payable on it.

Had the new drug been available at the time of the original illness he might have succeeded in remaining in the Merchant Navy or, at least, in obtaining suitable alternative employment without rehabilitation. If modern techniques of rehabilitation had been available at the time of his illness, but without the new drug, it is probable that he could have been resettled in suitable employment even though the tremor could not be controlled. Finally, if instead of being a merchant seaman, he had been employed by a large firm, with a variety of work to offer, his employer might well have found him a job he could do in spite of his disability and no expenditure on rehabilitation would have been necessary.

This case shows the inter-relationship between the disease, definitive treatment and employment and how difficult it is to evaluate rehabilitation as such. All that can be said is that in the particular circumstances obtaining in this case it has cost so much to provide some, but not all, services concerned in his rehabilitation and that, provided he retains his present employment and rate of pay for a certain period, the expenditure will have been justified on economic grounds alone.

Case 2

A male aged sixty-three. At the age of fifty-six, after many years of regular work as a maintenance handyman, he developed heart trouble. At first this was thought to be of serious import and he was advised that he would be permanently unfit to return to his normal work. However, further investigation soon revealed that he had a nervous disorder of the heart from which he recovered completely. Nine months after the onset he was advised to start light work and to " find his way back " to his ordinary employment.

The patient failed to return to work, partly because of the difficulty of finding light work in his trade, but mainly because he had been badly frightened by the original gloomy prognosis and, subsequently, he had not been adequately reassured. He was recommended for rehabilitation and in two months the hospital department had fully restored physical fitness for his type of work. However, he remained unduly apprehensive and the many employers to whom he was submitted by the disablement resettlement officer refused to employ him because of his age and the reservations he insisted on making about undertaking certain tasks.

Eventually arrangements were made with the hospital engineer for him to work in a voluntary capacity with the maintenance staff, starting at three hours a day. After two months his confidence was fully restored and he was offered employment on the staff. He has been employed by the hospital ever since and he has proved to be a fit and exceptional workman.

Here again it is possible to estimate the loss of wages and cost of rehabilitation as such, but two factors make the figures valueless. Firstly, had he been given adequate medical reassurance early in his illness he would not have needed rehabilitation except possibly a short course of graduated remedial exercises in the convalescent period. Secondly, but for the fortuitous and unorthodox circumstances of the opportunity for graduated return to work within the hospital in which he had exceptional confidence, his resettlement might well have been a long and costly business.

On reflection, reference to an industrial rehabilitation unit might have restored his confidence but, in view of his apparent fitness for his normal work, this course did not seem necessary at the time. Moreover, in view of his age and anxious disposition it is doubtful if he would have surmounted the step to open industry without an intermediate stage.

Case 3

A female aged thirty-nine. At the age of thirty-four she was permanently paralysed by poliomyelitis in the whole of the left shoulder girdle, arm, forearm and hand; also in the right shoulder and arm, including elbow movement. The right forearm and hand were unaffected except for some weakness of the thumb. Her husband was engaged in shift work on public transport and she had a child of three. She was advised that she and her family should move to the north to live with her sister and brother-in-law since it appeared that she would be able to contribute little or nothing to the running of her own home. However, whilst receiving physiotherapy, attempts were made to teach her to be as independent as possible of the help of other people. Fortunately she was a woman of great courage and it proved possible to teach her not only to be completely independent in her own personal activities but also, through various adaptations, to do much of her own housework. Fourteen months after the onset of the paralysis she was resettled with her husband and child in a bungalow, and a home help was provided for two hours a day to do the heavier work.

This appeared to be the conclusion of the case and, as far as rehabilitation was concerned, there would appear to be a negative economic balance. That is to say, her rehabilitation had been expensive and she would need a subsidised home help permanently whilst, as a housewife, she would earn no wages to offset the expenditure. Had she gone to live with her sister less would have been spent on her rehabilitation and there would have been no continuing charge for a home help. As it happens, with the passage of time this woman has learnt complete independence. Not only has she discharged her home help but, in addition to running her home, she does a lot of voluntary work for the hospital by visiting other disabled patients and encouraging them by her own experience and example.

Case 4

A woman aged fifty-four, who has suffered with rheumatoid arthritis of moderate severity for four years. Throughout this period she has been under more or less continuous medical treatment and has had frequent courses of physiotherapy. Two years ago serious consideration was given to her rehabilitation for the first time. Investigation revealed that social factors played a large part in perpetuating the symptoms for which she was seeking treatment.

At the time she was living with her husband, young son and daughter, married daughter, son-in-law and infant grandchild in a small five roomed cottage. On the ground floor there was a kitchen at the rear, which also served as a living room, and a front room which was occupied by the married daughter, her husband and infant. Upstairs the two small rooms served as bedrooms for the younger son and daughter and a larger room for the patient and her husband. However, the patient was so crippled by arthritis that she was unable to climb the stairs. For months she had been sitting all day and sleeping at night in an armchair in the living room and this largely accounted for the pain and stiffness in her joints for which she had had so much treatment. She was doing none of her housework except minor tasks which she could do on her lap, such as shelling peas and darning socks.

Arrangements were made to rehouse the married daughter, to convert the front downstairs room into a bedroom for the patient and her husband, and the patient was taught how to do her cooking and downstairs housework again with the aid of certain appliances.

The relief of physical discomfort and gross overcrowding has had a dramatic effect on this woman's health. She can climb the stairs again and is now doing all her housework and shopping. She has required no physiotherapy for the past two years and only needs an occasional dose of aspirin to relieve the comparatively minor pain in her joints which she still experiences.

Here again it is extremely difficult to prepare a true economic balance sheet. Presumably the cost of providing a new home for the married daughter must be taken into account and, again, as a housewife she has not returned to gainful employment. However, had she not been rehabilitated there is little doubt that sooner or later she would have had to be admitted to an institution for the chronic sick. The cost of such accommodation must be taken into account in considering the economic aspects of her rehabilitation.

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